2005

UMP Neighborhood

Administered by the Uniform Medical Plan

Certificate of Coverage

Self-Insured by the State of Washington

Effective January 1, 2005

Printed under the direction of the Washington State Health Care Authority Public Employees Benefits Board

HCA 57-100 (10/04)

Directory

If you have questions about…	Contact…
Medical/Surgical Issues	UMP Neighborhood Customer Service 1-888-380-2822 or 425-686-1218 (Seattle area), Monday-Friday, 8 a.m. to 6 p.m.
Appeals, First Level; Correspondence, Complaints, Preauthorization, Medical Review	UMP Neighborhood P.O. Box 34578 Seattle, WA 98124-1578 Fax: 425-670-3197
Benefit Information, Certificates of Coverage, I.D. Cards, Claim Forms, Claims Status	UMP Neighborhood P.O. Box 34850 Seattle, WA 98124-1850 **www.ump.hca.wa.gov**
Finding a Network Provider	1-888-380-2822 or 425-686-1218 (Seattle area) or **www.ump.hca.wa.gov**
Care System Changes	1-888-380-2822
Prescription Drugs **Member Services, Network Pharmacies, Preferred Drugs, Questions, Complaints**	Express Scripts, Inc. **www.express-scripts.com** 1-866-576-3862 Available 24 hours a day, 7 days a week
First-Level Appeals, Correspondence	Express Scripts, Inc. Attn: Pharmacy Appeals: WA5 Mail Route BLO390 6625 West 78th Street Bloomington, MN 55439 Fax: 1-877-852-4070 Enrollee phone: 1-866-576-3862 Provider phone: 1-800-417-8164
Drug Coverage Review and Preauthorization	1-800-417-8164 Provider to call on enrollee's behalf
Mail-Service Pharmacy (refills)	Express Scripts, Inc. **www.express-scripts.com** 1-866-576-3862
Claims from Non-Network Pharmacies	Express Scripts, Inc. WA5A P.O. Box 390873 Bloomington, MN 55439-0873
Case Management	1-888-759-4855
Eligibility and Enrollment	PEBB Benefits Services 1-800-200-1004 or 360-412-4200 Fax: 360-923-2602 Monday-Friday, 8 a.m. to 5 p.m. **www.pebb.hca.wa.gov**
Preventive Care Guidelines	**www.ahcpr.gov/clinic/gcpspu.htm** **www.cdc.gov/nip/publications/ACIP-list.htm**
Tobacco Cessation	*Free & Clear* 1-800-292-2336 Monday-Friday, 8 a.m. to 6 p.m. **www.freeandclear.org/brochure**
Address Changes	Contact your personnel, payroll, or insurance office
Washington Hotline Numbers	Alcohol and Substance Abuse 1-800-562-1240 Domestic Violence 1-800-562-6025 Emergency Contraception 1-888-668-2528 Family Planning 1-800-770-4334 HIV-AIDS (national) 1-800-342-2437 Poison Control 1-800-732-6985

This booklet explains benefit provisions specific to the UMP Neighborhood and is the certificate of coverage for UMP Neighborhood enrollees. (This certificate of coverage supersedes previous certificates.) If provisions in this booklet are inconsistent with any federal or state statute or rule, the language of the statute or rule will govern. This booklet was compiled by the Washington State Health Care Authority/Uniform Medical Plan, P.O. Box 91118, Seattle, WA 98111-9218. If you have any questions about these provisions, please contact UMP Neighborhood (see the Directory).

To Learn More About... See Page...

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To obtain this booklet in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

To Learn More About... See Page...

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Highlights

Welcome to UMP Neighborhood! UMP Neighborhood is offered by the Uniform Medical Plan (UMP), a self-insured plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Enrollment is offered only to residents of King, Pierce, and Snohomish counties. UMP Neighborhood is not available to retirees where all enrollees under the same account have Medicare as their primary coverage.

UMP Neighborhood coverage is designed to keep you and your family healthy in addition to providing benefits in case of illness or injury. As you know, your health care coverage can be one of your most important benefits. When you enroll in UMP Neighborhood, you must select a small, customized network of health care providers known as a "care system." To receive the highest benefit, you will usually need to seek care through your care system. The care systems for UMP Neighborhood were chosen based on the ability to provide cost-effective care and commitment to participate in clinical quality initiatives. Services outside the care system will usually result in higher out-of-pocket expense for you. Only urgent conditions and medical emergencies are covered outside of Washington State (see exceptions for Medicare-enrolled retirees and student dependents attending school outside the service area).

Please review this booklet carefully so that you can take advantage of all this product has to offer. In addition, you can visit the UMP Web site at **www.ump.hca.wa.gov** to access the following:

- Online accounts, where you can access your medical and pharmacy claims information through secure Web sites.
- Secure e-mail to submit questions to Customer Service (through your online account).
- Benefits information.
- Care system descriptions, including information on special programs and services offered.
- Prescription drug and pharmacy network information.
- Provider network and care system directories.
- UMP publications and forms.
- Links to health resources and Medicare information.
- Explanations of complaints and appeals processes.
- Frequently asked questions.

UMP Neighborhood Features

Here are a few important plan features:

- You and each family member choose a care system from which you receive most of your health care services. The care system you choose can be different from the care systems your other family members choose.
- If you need to change care systems during the plan year, 30 days' notice is required. If the new care system you've chosen is accepting new patients, your change will be effective the first of the month following the 30-day notice.
- UMP Neighborhood allows you to self-refer within your care system for most routine and specialist services without needing authorization from a primary care physician. You can also self-refer to UMP Preferred Provider Organization (PPO) providers outside your care system for alternative care services from chiropractors, acupuncturists, naturopathic physicians, as well as for women's health care and behavioral health services. Certain restrictions apply. Refer to the specific benefit under "Covered Expenses" beginning on page 23. In addition, see "Other Health Care Services" on pages 15-16 for specific information on those provider types you can see without a referral from your care system provider.
- Although you can see non-network providers in Washington outside of your care system (as long as they are an approved provider type), using the network providers available to you through UMP Neighborhood offers several advantages:
  - Higher level of coverage.
  - No claim forms for you to fill out.
  - Your enrollee coinsurance applies to your annual medical/surgical out-of-pocket limit.
  - Preventive care, preauthorized hospice services, and tobacco cessation services through *Free & Clear* are covered at 100% of allowed charges.
  - You're not responsible for differences between the provider's billed charge and the UMP allowed charge.
- All care must be medically necessary (as defined on pages 73-74) to be covered.

- Enrolling in UMP Neighborhood also gives you access to network pharmacies nationwide, where you can purchase retail prescription drugs at discounted rates—with no claim forms to worry about. You do not need to use a pharmacy affiliated with your care system. You may also order prescriptions through our mail-service pharmacy. See pages 31-32 for details on your prescription drug benefits.
- Preventive care, routine vision exams and hardware, and required second opinions are not subject to the annual medical/surgical deductible.
- Only urgent conditions and medical emergencies are covered outside of Washington State (see exceptions on pages 51-52 for Medicare-enrolled retirees, and on page 7 for student dependents attending school outside the service area).

If Medicare is your primary coverage, please refer to "UMP Neighborhood Provisions for Retirees on Medicare" starting on pages 51-52. UMP Neighborhood care systems and restrictions on out-of-state services may not apply to you.

How to Use the Plan

- Upon enrollment, you and each enrolled family member will be required to choose a care system. Once you have enrolled in a care system, you can self-refer to any provider included in that care system; however, please note that physical, occupational, speech, and massage therapy require a prescription and plan of treatment from the clinician overseeing your care.
- If you need specialized care that cannot be provided by the physicians and facilities in your chosen care system, your physician can refer you outside of your care system.
- If your care system provider refers you to a UMP PPO network provider for covered services unavailable within the care system, coverage is provided at the network benefit level. If your care system provider refers you to a provider who is not contracted with the UMP PPO network, coverage will be at the out-of-network level.
- If you use the services of a provider outside your care system (with the exception of network providers listed under "Other Health Care Services" described on pages 15-16) *without* a referral from your care system provider, your out-of-pocket costs will be much higher. Non-urgent/non-emergent services outside of Washington State will not be covered at all.
- You can use licensed pharmacies throughout the U.S., but it will benefit you to use UMP network pharmacies. See page 16 for details.
- When Medicare is your primary coverage, you receive network benefits when you choose a UMP PPO network provider in Washington, Oregon, or in the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce; or a doctor who accepts Medicare assignment.
- Identify yourself as a UMP Neighborhood enrollee when you make an appointment with your care system or UMP network provider.
- Present your UMP Neighborhood I.D. card when you receive health care services or have a prescription filled. When UMP Neighborhood is the primary payer (see definition on page 75), the network provider or network pharmacy will submit the claim for you.
- Remember that some services and prescription drugs require medical review/preauthorization by UMP Neighborhood (see pages 19-20 for details). This discourages unnecessary care, saves money for you and UMP Neighborhood, and helps ensure the treatment and drugs you receive are necessary and appropriate. Although you're responsible for obtaining medical review/preauthorization from UMP Neighborhood for these services or supplies, your care system or network provider may assist you with this process. Network pharmacies can assist you with prescription drug review, if applicable.

If you move out of the UMP Neighborhood service area (King, Pierce, and Snohomish counties) during the plan year and choose to enroll in UMP PPO, any amounts paid or services received as a UMP Neighborhood enrollee will ***not*** *count towards the UMP PPO deductibles, benefit limits, or annual out-of-pocket limit. New deductibles, benefit limits, and out-of-pocket limits will apply (see pages 5-6), and your monthly premium will increase as of the date of coverage under UMP PPO.*

Your Rights and Responsibilities as a UMP Neighborhood Enrollee

To ensure UMP Neighborhood offers the best possible medical care, we must work together with you and your providers as partners. To achieve this goal, you must first know your rights and responsibilities.

As a UMP Neighborhood enrollee, you have the right *to:*

- Be treated with respect.
- Be informed by your providers or the UMP about all appropriate or medically necessary treatment options

for your condition, regardless of cost or benefit coverage.

- Have information about:
  - How new technology is evaluated for inclusion as a covered benefit.
  - How providers are reimbursed by UMP Neighborhood.
  - Preauthorization and review requirements.
  - Providers you select and their qualifications.
  - UMP Neighborhood and our network of providers.
  - Your covered expenses, exclusions, and maximums/limits.
- Keep your medical records and personal information confidential.
- Obtain a second opinion regarding your provider's care recommendations.
- Make decisions in consultation with your providers about your health care.
- Make recommendations about enrollee rights and responsibilities.
- Have a translator's assistance, if required, when calling UMP Neighborhood.
- Receive:
  - All medically necessary covered services and supplies described in your *Certificate of Coverage*, subject to the maximums/limits, exclusions, deductibles, and enrollee coinsurance/copays.
  - Clear information from your provider about illness or treatment before services and supplies are provided.
  - Courteous, prompt answers from UMP.
  - Timely, proper medical care without discrimination of any kind—regardless of health status or condition, sex, ethnicity, race, marital status, or religion.
  - Written explanation from UMP regarding any request to refund an overpayment.
- Voice complaints or initiate appeals about UMP Neighborhood services, decisions, or the care you receive.

As a UMP Neighborhood enrollee, you have the responsibility *to:*

- Complete and return the annual coordination of benefits questionnaire you receive from UMP Neighborhood in a timely manner to prevent delay in claims payment.
- Comply with requests for information by the date given.
- Follow your providers' instructions about your health care.
- Give your providers complete information about your health to get the best possible care.
- Keep your providers' phone numbers handy and know how to make or cancel an appointment as well as how to reach your providers after hours.
- Know how to access emergency care.
- Not engage in fraud or abuse in dealing with UMP or your providers.
- Participate with your providers in making decisions about your health care.
- Pay your copayments, coinsurance, or deductibles promptly.
- Refund promptly any overpayment made to you or for you.
- Report to UMP any outside sources of health care coverage or payment as well as any changes in your dependents or in your address.
- Show the same respect to your providers and UMP as you expect from them.
- Understand your UMP Neighborhood benefits, including what's covered, preauthorization and review requirements, and other information described in this *Certificate of Coverage*.
- Use UMP Neighborhood care system and network providers when available to help ensure quality care at the lowest cost.

Disclosure Information

We support the goal of giving you and your family the detailed information you need to make the best possible health care decisions. The following information can be found in this *Certificate of Coverage*:

- List of covered expenses (see pages 23-39).
- Benefit exclusions, reductions, and maximums/limits (see pages 40-43).
- Clear explanation of complaint and appeal procedures (see pages 47-50).
- Preventive health care benefits that are covered (see pages 32-37).
- Definition of terms (see pages 70-76).

The following information is available on the UMP Web site at **www.ump.hca.wa.gov**, or by calling UMP Neighborhood Customer Service at 1-888-380-2822.

- Accreditation information, including measures used to report health plan performance such as consumer satisfaction survey results or Health Employer Data Information Set (HEDIS) measures.
- Annual accounting of all payments made by UMP Neighborhood that have been counted against any payment limits, day limits, visit limits, or other limits on your coverage.
- Description and justification for provider compensation programs, including any incentives or penalties intended to encourage providers to withhold services.
- Documents and other materials referred to in PEBB open enrollment materials or this *Certificate of Coverage*.
- General reimbursement or payment arrangements between UMP Neighborhood and network providers.
- How you can be involved in decisions about benefits.
- Information on UMP Neighborhood's disease management programs.
- List of network providers, including both primary care providers and specialists.
- Notice of privacy practices (includes UMP policy for protecting the confidentiality of health information; see "Confidentiality of Individually Identifiable Health Information" on this page).
- Preferred drug list, including policies regarding drug coverage and how drugs are added to or removed from the list.
- Procedures to follow for consulting with providers.
- Process for preauthorization/review.
- When UMP Neighborhood may retrospectively deny coverage for preauthorized care.

UMP Neighborhood does not prevent or discourage providers from informing you of the care you require, including various treatment options and whether, in the provider's view, that care is consistent with UMP Neighborhood's coverage criteria. You may, at any time, obtain health care outside of UMP Neighborhood coverage for any reason; however, you must pay for those services and supplies. In addition, UMP Neighborhood does not prevent or discourage you from discussing the merits of different health care insurers with your provider.

Confidentiality of Individually Identifiable Health Information

UMP Neighborhood abides by our Notice of Privacy Practices, available online at **www.ump.hca.wa.gov/members/planinfo/privacypractices.shtml,** or by calling Customer Service at 1-888-380-2822 to request a copy. Enrollee health information will be disclosed only with the consent or authorization of that enrollee or of someone authorized to give consent or authorization on the enrollee's behalf, as required or permitted by law or court order, or as needed to handle claims.

Your Cost-Sharing Requirements

Medicare-entitled retirees: Be sure to read "If You Have Other Medical Coverage" starting on page 51.

Annual Medical/Surgical Deductible

A deductible is a dollar amount you must pay before UMP Neighborhood will pay most benefits. The annual medical/surgical deductible is $200 per person and is calculated from January 1 to December 31, even if you're enrolled for only part of the year. For example, a person enrolled in July would still have to pay the entire annual medical/surgical deductible for that year before the plan would reimburse for medical/surgical benefits, then would have to pay a new medical/surgical deductible beginning in January next year.

The maximum annual medical/surgical deductible, payable by all family members combined under one subscriber's account, is $600 (for families of three or more covered persons). When a family's total annual medical/surgical deductible reaches this amount, no further medical/surgical deductible will be required for any family member during that calendar year.

Medical/surgical services are subject to their own annual medical/surgical deductible, and do not apply to the annual prescription drug deductible.

Please note: Charges applied to your annual deductible also count toward any applicable benefit maximum or limit. For example, spinal manipulations have a visit limit of 10 per year. If you pay out-of-pocket for three visits that count toward your annual deductible, those three visits also count toward your 10-visit limit. You would then have seven visits remaining under your UMP Neighborhood coverage for the rest of that year.

Benefits Not Subject to the Annual Medical/Surgical Deductible

The following services are exempt from the annual medical/surgical deductible—they will be paid according to their own reimbursement schedules, even if the annual medical/surgical deductible has not been met:

- Preventive care benefits listed on pages 32-37.
- Required second opinions.
- Routine eye exams and vision hardware.
- Services received under the *Free & Clear* tobacco cessation program.

Annual Prescription Drug Deductible

The annual prescription drug deductible is $100 per person, calculated for prescriptions purchased from retail pharmacies and our mail-service pharmacy from January 1 to December 31. The maximum annual prescription drug deductible, payable by all members of a family combined under one subscriber's account, is $300 (for families of three or more covered persons). Like the annual medical/surgical deductible, you must meet your full annual prescription drug deductible even if you enroll near the end of the year.

Prescription drugs are subject to their own annual prescription drug deductible, and do not apply to the annual medical/surgical deductible.

Coinsurance

Coinsurance is the percent of allowed charges that UMP Neighborhood pays for medically necessary covered services; *enrollee* coinsurance is the percent you're required to pay (when UMP Neighborhood pays less than 100%). See the "Summary of Benefits" charts on pages 7-13 for coinsurance levels.

Copayments

A copayment is a dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a Washington care system facility, emergency room care, or a prescription filled through our mail-service pharmacy. See the "Summary of Benefits" charts on pages 7-13 for specific copayment requirements.

Annual Medical/Surgical Out-of-Pocket Limit

This out-of-pocket limit refers to the maximum total amount that you may be required to pay for most enrollee coinsurance and copayments each calendar year. Once your eligible enrollee coinsurance and copayment costs reach $1,125 per person or $2,250 per family (all family members combined under one subscriber's account), most medical/surgical network or out-of-network (see page 75 for definition) claims for covered services are paid at 100% of allowed charges for the remainder of the calendar year.

After you have reached your annual medical/surgical out-of-pocket limit, you will still be responsible for the difference between your provider's billed charge and UMP Neighborhood's allowed charge for out-of-network services (see pages 14-15 for the difference between out-of-network and network services).

The following costs are **not** counted towards your annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for services from non-network providers.

Non-network providers are covered at 60% of allowed charges regardless of whether or not you have satisfied your out-of-pocket limit. In many cases, a provider's billed charge is higher than the UMP's allowed charge. Your financial responsibility when using non-network providers is the combination of the 40% coinsurance plus the difference between billed and allowed charges.

Maximum Plan Payment

The total UMP Neighborhood will pay for all benefits is limited to a lifetime maximum of $2,000,000 per enrollee. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by UMP Neighborhood during the prior calendar year. Some services are also subject to specific calendar year or other benefit limits, as detailed in the "Summary of Benefits" starting on page 7.

Summary of Benefits

This section summarizes your UMP Neighborhood benefits.

Please note that UMP Neighborhood has no waiting period for coverage of preexisting conditions.

If Medicare is your primary coverage, please refer to "UMP Neighborhood Provisions for Retirees on Medicare" starting on page 51. UMP Neighborhood care systems and restrictions outside the service area may not apply to you.

Student dependents attending school outside King, Pierce, and Snohomish counties may access all covered services, routine and emergent, from approved provider types outside the service area. After deductibles are met, benefits for care from providers outside the service area of King, Pierce, and Snohomish counties will generally be paid either at 90% of allowed charges (UMP PPO providers within Washington State, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce) or at 80% of allowed charges (all other providers, including providers out-of-state). Parents with student dependents expecting to get out-of-area care should call Customer Service at 1-888-380-2822 for more detailed instructions and information.

Network reimbursement level applies to:

- Covered services provided by all providers within your UMP Neighborhood care system;
- Covered services provided by UMP PPO network providers when your care system provider has notified UMP that he or she has referred you for medically necessary care not obtainable within your care system; or
- UMP PPO network provider services for which you can self-refer such as alternative care, women's health care, and behavioral health (see "Other Health Care Services" on pages 15-16 for details).

Non-network reimbursement level applies to:

- Self-referrals to Washington State providers outside your care system other than self-referrals that are permitted under this plan (see "Other Health Care Services" on pages 15-16).
- Services from providers outside your care system when UMP is not notified by your care system provider of a referral.

Out-of-network reimbursement level (80% of allowed charges) applies to:

- Care system provider referrals for medically necessary services to a provider who does not contract with the UMP PPO network; or
- Services by a non-network provider received for an urgent condition or medical emergency.

Conditions treated outside Washington State that are not considered urgent or medical emergencies are not covered.

UMP Neighborhood covers only medically necessary services and supplies, as defined on pages 73-74. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details. For any UMP Neighborhood covered benefit, once you have met the cost-sharing requirements, UMP Neighborhood pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percent paid by UMP Neighborhood refers to percent of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 72).

Only the *allowed charge* is covered—the maximum payment UMP Neighborhood allows for a specific service or supply (see definition on page 70). In many cases, UMP Neighborhood's allowed charge is less than the provider's billed charge for the service. This means that for most non-network and out-of-network services, you will be responsible for not only the enrollee coinsurance but also the difference between the billed and allowed charges.

In most circumstances, UMP Neighborhood follows Medicare policy related to claims payment policies and procedures.

Some services also have specific limits, as shown in the summary charts.

The following sections describe your UMP Neighborhood benefits along with other details you'll need to use your coverage effectively. If you have questions, see the Directory (inside the front cover) for contact information.

Summary of Benefits

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Acupuncture 16 treatments max/year	90%	60%	No	23, 40
Ambulance Air and ground	80%	80%	No	23, 40, 73
Biofeedback (if for mental health diagnosis, see Mental Health benefits)	90%	60%	No	23, 28
Blood and Blood Derivatives	90%	60%	No, except stem cell harvesting for transplant purposes	24, 40
Bone, Eye, and Skin Bank Services	90%	60%	No	24
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	20, 24
Chemical Dependency Treatment $12,500 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient combined (excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				24, 40, 43, 71, 76
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient**	90%	60%	No	
Dental Services (limited – does not include routine dental care, or most common dental services)	90%	60%	No, except surgical treatment of TMJ	24, 40
Diabetes Education	90%	60%	No	18, 25, 41

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Diagnostic Tests, Laboratory, and X-Rays (outpatient)	90%	60%	Certain services	25
Dialysis	90%	60%	No	25, 41
Durable Medical Equipment, Supplies, and Protheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	90%	60%	Yes, for rentals over 3 months and purchases over $1,000	20, 25-26, 41, 71
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit	90% after $75** copay/visit	80% after $75** copay/visit	No	19, 26, 73
Hearing Care $400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	26, 41
Home Health Care	90%	60%	Yes	26-27, 41, 42, 72
Hospice Care				20, 27, 41, 43, 73
• **Inpatient**				
When preauthorized	100%	60%	Yes	
When NOT preauthorized	90%	60%	No	
• **Respite Care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				20, 27,
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	No; see "Physical, Occupational, Speech, and Massage Therapy" for exceptions.	42
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	27, 43

(continued on next page)

* Not subject to the annual medical/surgical deductible.

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For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Mammograms				
• **Screening mammograms*** (beginning at age 40, every one or two years)	100%	60%	No	25, 37
• **Diagnostic mammograms**	90%	60%	No	25
Mastectomy and Related Services	90%	60%	No	27-28
Mental Health Treatment				28, 42, 43, 75
• **Inpatient:** 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No, except for partial hospitalization services	
• **Outpatient:** 20 visits max/year	90%	60%	No	
Naturopathic Physician Services	90%	60%	No	28, 40, 41
Neurodevelopmental Therapy (Ages 6 years and under)				29, 30-31, 42
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
Obstetric and Newborn Care				29
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay)	60%	No	
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

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For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Office, Clinic, and Hospital Visits	90%	60%	No	29, 40, 42
Organ Transplants				20, 30, 42
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• **Outpatient** Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
Out-of-Network Care[1] See definition on page 75.	Not applicable	80%	Varies by service/ supply	15, 42, 75
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	60%	No	30, 43, 70
Phenylketonuria (PKU) Supplements	90%	60%	No	30, 40
Physical, Occupational, Speech, and Massage Therapy				20, 30-31, 42
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• **Outpatient:** 60 visits max/year	90%	60% (massage therapists not covered)	No, but treatment plan required	

(continued on next page)

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

[1] If Medicare is the primary payer, all services received outside of Washington, Oregon, and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce will be paid as out-of-network.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Summary of Benefits, continued

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is often less than the provider's billed charge. Note:** If Medicare is the primary payer, all services outside of Washington, Oregon, or the Idaho counties of Bonner, Kootenai, Latah, or Nez Perce, will be paid as out-of-network.

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Prescription Drugs* (up to a 90-day supply)				21-22, 31-32, 40, 41, 42, 43, 71, 72, 75
• **Retail pharmacies****: Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $50 per prescription for up to 30 days' supply, $100 per prescription for 31-60 days' supply, and $150 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescriptions purchased at non-network pharmacies.				
Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies	80% (enrollee coinsurance is 20% or cost share limit, whichever is less)	80%	Certain drugs	
Tier 2: Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	50%	50%	Certain drugs	
• **Mail-Service pharmacy****: Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.				
Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies	100% after $10 copay/refill	Not covered	Certain drugs	
Tier 2: Preferred brand-name drugs	100% after $40 copay/refill	Not covered	Certain drugs	
Tier 3: Nonpreferred brand-name drugs	100% after $80 copay/refill	Not covered	Certain drugs	

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

Benefits	Plan payment for care system network services	Plan payment** for non-network services	Preauthorization required?	See page***
Preventive Care* See specific services covered	100%	60%	No	32-37, 40, 42
Radiation and Chemotherapy	90%	60%	No	38
Second Opinions				20, 38
• **When required by UMP***	100%	100%	No	
• **When optional**	90%	60%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	20, 38, 40, 42, 43, 76
Special Nursing Services $5,000 max/year	90%	60%	No	38, 43
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No	38, 42
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	60%	Yes	20, 38, 40
Tobacco Cessation Program* *Free & Clear* program only	100%	Not covered	No	38-39, 43
Vision Care*				
• **Eye exams** (routine)—Once every two calendar years	90%	60%	No	39, 42
• **Vision hardware**—Including frames, lenses, contact lenses, and fitting fees combined	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services* See specific services covered under "Preventive Care"	100%	60%	No	33-35, 40, 42

* Not subject to the annual medical/surgical deductible.

** Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 11.

*** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

For more information on what isn't covered and benefit limits, see "Expenses Not Covered, Exclusions, and Limitations."

How UMP Neighborhood Works

Care Systems and UMP Neighborhood Provider Network

When you choose UMP Neighborhood, you must enroll in a small, customized network called a "care system." While you may receive coverage for services performed by providers outside your selected care system (if they are within Washington State and are of an approved provider type; see list on pages 18-19), your out-of-pocket expenses will be less when you access services through a provider affiliated with your care system or a network pharmacy. However, for certain provider types (see list on pages 15-16), you may receive network-level reimbursement for services from any provider in the UMP PPO network. When you use network providers, you'll be responsible only for any deductibles, enrollee coinsurance, and copayment along with expenses not covered (see the section starting on page 5), and charges that exceed benefit maximums/limits.

If you use an out-of-network provider or a non-network provider or pharmacy, you'll also be responsible for amounts that exceed UMP Neighborhood's allowed charge (defined on page 70), in addition to your cost-sharing requirements and any expenses not covered.

When UMP Neighborhood is the primary payer (see definition on page 75 and "If You Have Other Medical Coverage" on pages 51-53), care system or network providers and pharmacies will submit your claims and call to request any required medical review/preauthorization, saving you money on your share of the bill. If you use an out-of-network provider or a non-network provider or pharmacy, you'll be responsible for obtaining any required medical review/preauthorization, and you may have to pay for services and submit a claim form before you receive reimbursement from UMP Neighborhood.

You and each covered dependent may choose different care systems.

If Medicare is your primary coverage (see pages 51-52) or if you are a student dependent attending school outside the service area (see page 7), care system and service area coverage restrictions may not apply to you.

Changing Care Systems

If you would like to change your care system during the plan year, a 30-day notice is required. Call UMP Neighborhood Customer Service at 1-888-380-2822. If the new care system you have chosen is accepting new patients, your change will be effective the first of the month following the 30-day notice.

If you obtain care from a clinic in a different care system without first changing your care system selection, UMP Neighborhood's non-network reimbursement level will apply.

Your Medical/Surgical Provider Options

Note: If you are enrolled in Medicare, see "UMP Neighborhood Provisions for Retirees on Medicare" starting on page 51. If you are a student dependent attending school outside the service area (see page 7), call Customer Service at 1-888-380-2822 for exceptions.

For all other UMP Neighborhood enrollees, medical/surgical provider options are described below:

Network Providers

Network providers include:

- Care system providers.
- Certain other provider types (see "Other Health Care Services" on pages 15-16 for details) who have contracted directly with the UMP PPO network, or are part of a network that has contracted with UMP to render services to UMP Neighborhood enrollees at a reduced rate.
- Other UMP PPO network providers, if your care system provider has notified UMP Neighborhood that you have been referred for medically necessary care not obtainable within your care system.

Network providers agree to accept UMP Neighborhood's allowed charge as payment in full for covered services. They cannot bill you for the difference between their billed charge and UMP Neighborhood's allowed charge. And using a network provider means that you don't have to file claims. **Exception:** For services not covered by UMP Neighborhood, network providers can bill their usual and customary charge.

See the summary tables starting on page 7 for the cost-sharing requirements that apply to services you receive from network providers. Your enrollee coinsurance (generally 10%) for care from a care system or network provider *does* apply to your annual medical/surgical out-of-pocket limit once your annual medical/surgical deductible has been met.

Preventive care and preauthorized hospice services are covered at 100% of allowed charges when you use network providers.

To locate a network provider in Washington State, you may use the UMP Neighborhood's online provider directory on the UMP Web site at **www.ump.hca.wa.gov**, or call UMP Neighborhood Customer Service at 1-888-380-2822 or 425-686-1218 in the Seattle area. You may also get a printed copy of the directory from Customer Service. However, please note that you will receive the most up-to-date information by calling Customer Service, as provider status may change after the directory is printed.

Out-of-Network Providers

Out-of-network providers refer to providers:

- Who do not have a contract with the UMP and to whom you have been referred by your care system provider for covered services not available within your care system, or
- To whom you have self-referred for urgent conditions or medical emergencies.

UMP Neighborhood's reimbursement rate is 80% of allowed charges after your annual medical/surgical deductible has been met. Most out-of-network providers can bill you for the difference between their billed charge and UMP Neighborhood's allowed charge (see definition on page 70). Your enrollee coinsurance (20%) for care from an out-of-network provider *does* apply to your annual medical/surgical out-of-pocket limit.

Non-Network Providers

Non-network providers are health care providers in Washington State who are not listed in your care system directory and to whom you self-refer (except for the UMP PPO network providers identified in "Other Health Care Services" on pages 15-16).

Non-network providers can bill you for the difference between their billed charge and UMP Neighborhood's allowed charge. This does not apply to providers who are contracted with the UMP PPO network.

UMP Neighborhood's reimbursement rate for non-network services is 60% of allowed charges after your annual medical/surgical deductible has been met.

Your enrollee coinsurance (40%) for care from a non-network provider does **not** apply to your annual medical/surgical out-of-pocket limit.

Other Health Care Services

For certain types of providers (see list below), the large UMP PPO network is available to you no matter which UMP Neighborhood care system you are enrolled in. In some cases, care systems will also list these provider types in their directories to indicate providers who are affiliated with or are recommended by the care system. However, you receive network level coverage when you self-refer to a UMP PPO network provider of any of the following provider types:

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ambulatory Surgical Centers (ASC)
- Audiologists
- Behavioral Health Counselors, including Licensed Mental Health Counselors, Licensed Masters of Social Work, Licensed Marriage and Family Therapists, and Licensed ARNPs with training in psychology and counseling
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- *Free & Clear* tobacco cessation program
- Free standing optometry clinics
- Hearing aid fitters and dispensers
- Home health or hospice agencies
- Home infusion provider
- Massage practitioners (requires a written treatment plan from your care system clinician, and must be a UMP PPO network provider)
- Midwife
- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)
- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacists
- Pharmacies
- Prosthetic and orthotic suppliers
- Psychologists (licensed)
- Psychiatrists (licensed)
- Skilled nursing facilities
- State mental hospital
- Vision hardware vendors

To find out whether a provider is contracted with the UMP PPO network, see the UMP PPO online directory

at **www.ump.hca.wa.gov** or call UMP Neighborhood Customer Service at 1-888-380-2822.

Non-network massage therapists, mail-service pharmacies other than Express Scripts, and tobacco cessation programs other than *Free & Clear* are not covered.

Self-Referral for Women's Health Care

For covered women's health care services, UMP Neighborhood enrollees will receive network level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their care system. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care.
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned, or other health services particular to women.
- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

Your Prescription Drug Provider Options

Although the prescription drug benefit differs based on whether drugs are purchased at a network or non-network pharmacy, it does not differ based on geographic location. In addition to network and non-network retail pharmacies, you also have the choice of filling your prescriptions through our mail-service pharmacy. You may receive up to a 90-day supply of medication, as prescribed by your physician, through either a retail or our mail-service pharmacy.

Retail Pharmacies

The UMP contracts for network pharmacies through Express Scripts, Inc. to serve UMP Neighborhood enrollees. Network pharmacies are available nationwide, and have agreed to provide prescription drugs at a discounted rate. You do not need to use a pharmacy affiliated with your care system. Although you may use any licensed pharmacy, a UMP network pharmacy will save you time and money by collecting only your annual prescription drug deductible and applicable enrollee coinsurance at the point of sale, and filing your claims for you. In addition, by using network pharmacies, you'll have the advantage of a cost-share limit on Tier 1 and Tier 2 drugs (see page 17).

At non-network pharmacies, you won't receive a discounted rate; the Tier 1 and Tier 2 cost-share limit doesn't apply; and you're required to pay the full cost of the prescription at the pharmacy, submit the claim to UMP Neighborhood, and wait for reimbursement.

Transferring to a network pharmacy is easy. Just contact the network pharmacy of your choice, tell them you are a UMP Neighborhood enrollee and would like them to transfer your prescriptions from your current pharmacy. Be ready with the name and phone number of your current pharmacy as well as the prescription numbers or drug names and dosages. The UMP network pharmacy will do all the work.

At network and non-network retail pharmacies, you pay a coinsurance based on a percentage of the allowed charge for the prescription. If you purchase a prescription at a non-network pharmacy and the amount charged by the pharmacy is higher than UMP Neighborhood's allowed amount, you are responsible for the cost difference. The enrollee coinsurance varies according to the drug "tier" as described in the chart on page 17.

UMP Neighborhood does not recognize or contract with other Internet or mail-service pharmacies—only the Express Scripts, Inc. mail-service pharmacy.

Mail-Service Pharmacy

UMP Neighborhood also offers prescription drugs through our network mail-service pharmacy. After you meet the annual prescription drug deductible, you pay a fixed dollar copayment per prescription or refill, based on the applicable drug "tier" as described in the chart on page 17. To order a prescription or refill by mail, you may visit the UMP Web site at **www.ump.hca.wa.gov**, or call Express Scripts Member Services at 1-866-576-3862.

Your Prescription Drug Benefit Amount

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 31-32 for details on both the retail and mail-service pharmacy benefits.

The amount you pay for a prescription is determined by the tier level the drug falls in (see table on page 17). The UMP Preferred Drug List (UMP PDL) is a list of prescription

drugs that have been identified as providing safe, cost-effective treatment. Generic drugs have the same active ingredient as their brand-name counterparts and are usually less expensive. Using generic and preferred drugs reduces costs both for you and for UMP Neighborhood. You may still choose nonpreferred drugs, but you will generally pay more if you do.

UMP Preferred Drug List

The UMP PDL includes drugs from the Washington Preferred Drug List (Washington PDL) and Express Scripts' National Formulary. Development and maintenance of the UMP PDL is a dynamic process. The Washington PDL is based on recommendations by the Washington Pharmacy & Therapeutics Committee (P&T Committee), an independent group of practicing health care providers that meets quarterly to help ensure that the content is medically sound and supportive of your health. It is updated periodically as new information and drugs become available. Once these reviews are completed, the UMP PDL may change based on the P&T Committee's recommendations. UMP uses the Express Scripts' National Formulary for drug classes not yet reviewed by the P&T Committee.

UMP retains the right to update the UMP PDL or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. UMP will notify enrollees of changes made to the UMP PDL or Drug Coverage Management programs if these occur during the plan year.

Limits on Specialty Drugs

Specialty drugs on the UMP PDL are limited to a 30-day supply at your retail pharmacy. Up to a 90-day supply (as ordered by your prescribing provider) is available through UMP's mail-service pharmacy.

After you have met your annual prescription drug deductible, your cost-share for a prescription or refill is:

Tier	Enrollee's cost at a network retail pharmacy (for up to a 90-day supply per prescription or refill)	Enrollee's cost using mail-service pharmacy (for up to a 90-day supply per prescription or refill)
Tier 1		
Generic drugs, all insulin, and all disposable diabetic supplies	Lesser of 20% coinsurance or enrollee cost-share limit (see below*)	$10 copay (see below**)
Tier 2		
Preferred brand-name drugs	Lesser of 30% coinsurance or enrollee cost-share limit (see below*)	$40 copay (see below**)
Tier 3		
Nonpreferred brand-name drugs	50% coinsurance Maximum cost-share limit does not apply	$80 copay (see below**)

* ***Enrollee cost-share limit:*** *For up to a 30-day supply, the limit is $50. For a 31- to 60-day supply, the limit is $100. For a 61- to 90-day supply, the limit is $150. The maximum enrollee cost-share limit does not apply to Tier 3 drugs or drugs purchased at a non-network pharmacy.*

** *If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.*

Enrollees who use the network mail-service pharmacy have the additional convenience of requesting refills online by accessing Express Scripts' Web site through the UMP Web site at **www.ump.hca.wa.gov**.

To find out which drugs are listed as preferred:

- Review the UMP *Guide to Preferred Drugs*;
- Visit the UMP Web site at **www.ump.hca.wa.gov** and link to the UMP Preferred Drug List; or
- Call Express Scripts, Inc. at 1-866-576-3862.

See "Covered Expenses" starting on page 23 and "Summary of Benefits" on pages 7-13 for more information on your prescription drug benefit.

Approved Provider Types

Only services performed by approved provider types are covered under UMP Neighborhood. The list of approved provider types below includes individual medical professionals, hospitals and other facilities or organizations, pharmacies, and programs.

To bill the UMP directly and receive payment in accordance with UMP Neighborhood benefits, the provider must:

- Be of a type appearing on the approved provider list;
- Have a current license, registration, or certificate to deliver services in his or her location;
- Perform only services within the provider's scope of practice, as defined by the licensing agency; and
- Provide services within UMP Neighborhood's benefit limits.

"Approved" does not indicate whether a provider is network, out-of-network, or non-network, nor whether preauthorization or other qualifications may apply.

Approved provider types include:

- Acupuncturists,* licensed (LAc).
- Alcohol/Chemical Dependency Centers and Substance Abuse Treatment Facilities,* licensed with Department of Social and Health Services (DSHS) certification (must be approved by the UMP); non-PhD psychologists and mental health counselors employed by these facilities are covered only when delivering services within an approved substance abuse facility *and* the facility bills for their services.
- Ambulatory Surgical Centers (ASC),* licensed (Medicare-certified or JCAHO or other recognized national accreditation).
- Audiologists,* certified.
- Biofeedback technicians, certified; covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Birthing centers,* licensed.
- Chiropractors,* licensed (Doctors of Chiropractic [DC]).
- Community mental health agencies,* licensed; non-PhD psychologists and counselors employed by these agencies are covered only when employed by and delivering services within a licensed community mental health agency *and* the agency bills for their services.
- Counselors,* licensed, including Licensed Marriage and Family Therapists (LMFT), Licensed Masters of Social Work (LMSW), Licensed Mental Health Counselors (LMHC), and Licensed ARNPs with training in psychology and counseling.
- Dentists, licensed (Doctors of Dental Medicine [DMD] and Doctors of Dental Surgery or Dental Science [DDS]) (see page 24 for limits on dental services covered).
- Diabetes education programs (including Medical Nutrition Therapy), Medicare-approved or otherwise approved by UMP.
- *Free & Clear* tobacco cessation program.*
- Hearing aid fitters and dispensers,* licensed.
- Home health aides, licensed (covered only when employed by and delivering services within a hospice or home health agency *and* that agency bills for their services).
- Home health or hospice agencies,* licensed (Medicare-certified or JCAHO-accredited).
- Hospitals, licensed.
- Massage practitioners,* licensed (LMP); only massage practitioners accepted into the UMP provider network are considered approved providers.
- Medical nutrition therapists (MNT), Medicare-approved or otherwise approved by UMP for the treatment of diabetes mellitus (see Diabetes education programs) or chronic renal insufficiency, end-stage renal disease when dialysis is not received, or medical conditions up to 36 months after kidney transplant. MNTs are covered only when employed by and delivering services within a hospital or other UMP-approved facility *and* the employing organization bills for their services.
- Midwife,* licensed (LM).
- Naturopaths,* licensed (Naturopathic Doctors [ND]).
- Nurses, licensed including Licensed Advanced Registered Nurse Practitioners (ARNP) and Licensed Certified Nurse Midwives (CNM) (all types must be licensed); see Practical Nurses, Registered Nurses, and Registered Nurse First Assistants.
- Occupational therapists, licensed (OT).
- Optometrists,* licensed (Doctors of Optometry [OD]).
- Pharmacists,* licensed and registered (RPh), or Doctors of Pharmacy (PharmD).
- Pharmacies,* licensed.

- Physical therapists, registered and licensed (RPT).
- Physicians, licensed (Doctors of Medicine [MD], or Doctors of Osteopathic Medicine [DO]). Self-referral to a psychiatrist* for behavioral health is allowed.
- Physician Assistants, licensed (PA) (covered only when providing services under the supervision of a clinician *and* the clinician who is supervising bills for their services).
- Podiatrists, licensed (Doctors of Podiatric Medicine [DPM]).
- Practical Nurses, licensed (LPN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Psychologists,* licensed (PhD).
- Registered Nurses, licensed (RN) (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Registered Nurse First Assistants, certified and licensed (covered only when providing services under the supervision of a clinician *and* the clinician who is supervising bills for their services; only *Certified* Registered Nurse First Assistants are covered).
- Respiratory therapists, licensed (covered only when employed by and delivering services within a hospital, skilled nursing facility, hospice, home health agency, or under the direction of a clinician *and* the employing organization or clinician bills for their services).
- Skilled nursing facilities,* licensed (Medicare-certified).
- Speech pathologists, licensed and certified by the American Speech, Language and Hearing Association.

*You receive network-level coverage when you self-refer to any UMP PPO network provider of these types within Washington State.

Services Received Outside the U.S.

Health care services may be covered outside of the U.S. as long as they:

- Are for urgent conditions or medical emergencies;
- Are provided by an approved provider type;
- Are medically necessary (see definition on pages 73-74);
- Are appropriate for the condition being treated;
- Are not considered to be experimental or investigational by United States standards; and
- Would otherwise be covered by UMP Neighborhood.

Services that meet the above criteria are generally covered at the out-of-network benefit level once the annual medical/surgical deductible has been satisfied.

Foreign claims and any requested medical records must be translated into English with specific services, charges, drugs and dosage documented, along with the currency exchange rate.

Emergency Care

In cases of accidental injury or medical emergency, call 911 or seek care immediately. If a UMP Neighborhood network facility or provider is not available, you should obtain services from the most conveniently available approved provider. See the "Summary of Benefits" charts for coverage details.

Medical Review/ Preauthorization Requirements

UMP Neighborhood includes a program to review and approve some medical services and supplies before, during, and after they're received. We have a medical review team to determine the appropriate treatment setting, whether the service or supply is medically necessary, if the service or supply has been accurately billed, and whether it is considered excessive. (The fact a service or supply is prescribed or furnished by a care system provider or an approved provider type does not, by itself, make it medically necessary; see definition on pages 73-74).

This program discourages unnecessary care, saves money for you and UMP Neighborhood, and helps ensure treatment is consistent with standards of good medical practice. Remember, you and your provider always make the final decision to proceed with, postpone, or cancel any admission, treatment, supply, or procedure.

All claims for hospital admissions are subject to retrospective review for medical necessity. Medical reviewers may approve a proposed admission, deny it and suggest alternative methods, or require a second opinion from another specialist.

The following services must be preauthorized by UMP Neighborhood. Your care system provider may assist you in obtaining this preauthorization from UMP Neighborhood, but it is your responsibility. Failure to obtain preauthorization prior to service may result in denial of your claim. To ensure you receive UMP Neighborhood benefits, call 1-888-380-2822 or 425-686-1218 in the Seattle area for preauthorization *before* receiving these services. Preauthorization requests may be faxed directly to the Medical Review Department at 425-670-3197.

- *Durable medical equipment, supplies, and prostheses*: Preauthorization is required for rentals beyond three months or for purchases over $1,000. UMP Neighborhood will not pay for any additional costs determined noncovered, such as more costly equipment that serves the same medical purpose (for example, an electric wheelchair instead of a manual wheelchair).

It also may be to your benefit to request preauthorization on some frequently prescribed durable medical equipment (such as light boxes, hospital beds, and breast pumps). This helps us address potential coverage issues in advance.

- *Home health care:* Preauthorization is required for cases in which:
  - Visits are daily;
  - Visits are expected to exceed two hours a day; or
  - Length of treatment is expected to last more than three weeks.

  Reauthorization is required every two weeks unless determined otherwise by Medical Review. Call 1-888-759-4855 before starting home health services; otherwise, your claim will be denied if services are later determined not medically necessary or other home health care requirements are not met.
- *Hospice care, including respite care:* Hospice care from UMP Neighborhood network providers is covered in full for up to six months when preauthorized. Respite care has a $5,000 lifetime maximum limit.
- *Organ transplants:* All organ transplants (including bone marrow, umbilical cord, and stem cell transplants) require preauthorization. You also must be accepted into the treating facility's transplant program and follow the program's protocol.
- *Specialty drugs* on the UMP Preferred Drug List that are not normally considered to be self-injectable (when obtained through a retail pharmacy or UMP's mail-service pharmacy).

Other services requiring preauthorization:

- Cardiac/pulmonary rehabilitation.
- Cochlear implants.
- Genetic testing (genetic testing unrelated to pregnancy is covered only when preauthorized and performed by a specialist center/provider designated by UMP Neighborhood).
- Inpatient admissions for rehabilitation (physical, occupational, speech, and massage therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services.
- Positron Emission Tomography (PET) scans.
- Skilled nursing facility admissions.
- Temporomandibular joint (TMJ) surgery.

"Summary of Benefits," "Covered Expenses," and "Expenses Not Covered, Exclusions, and Limitations" contain more information on all services and supplies that require preauthorization.

Obtaining an Estimate of Plan Benefits

Although only the services described in the previous section require preauthorization, you may want to confirm that the treatment you're considering is covered under UMP Neighborhood, is medically necessary, and will be paid at a certain level.

To obtain an estimate of plan benefits, call UMP Neighborhood. An estimate is not a guarantee of benefits; the actual benefits are determined when you submit a claim, based on specific services received.

Second Opinions

UMP Neighborhood's medical reviewers may require a second opinion before approving an admission or procedure. In this case, the second opinion will be paid at 100% of the allowed charge (for network, out-of-network, or in some cases non-network providers) and will not be subject to the annual deductible requirement. If you don't obtain a required second opinion, your benefits may be reduced by up to $200 or denied.

Optional Case Management

UMP Neighborhood offers an optional case management service at no cost for medical/surgical cases involving complex treatment or high expenses. These cases may be identified during the prenotification process, where hospitals notify UMP Neighborhood if you are admitted for a diagnosis that may require case management services. Optional case management services are performed under an agreement you and UMP Neighborhood enter before the case management begins.

Required Case Management

To promote quality health care, the UMP medical director may in some cases review medical records and determine that your use of certain services is potentially harmful, excessive, or medically inappropriate. Based on this determination, UMP Neighborhood may require you to participate in and comply with a case management plan as a condition of continued benefit payment. Case management may include designating a primary physician (MD or DO) to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP Neighborhood has the right to deny payment for any services received outside of the required case management plan, except medically necessary emergency services.

You have the right to appeal the medical director's determination and the required case management plan through the process outlined under "Complaint and Appeal Procedures" starting on page 47.

Medical Review During Claim Processing

When claims are processed, UMP Neighborhood will verify that treatment was medically necessary and will review provider charges. This may require the submission of medical records. UMP Neighborhood reserves the right of final determination in the amount payable for any service or supply.

Drug Coverage Management

Some medications are covered by UMP Neighborhood only for certain uses or in certain quantities. For example, since UMP Neighborhood excludes cosmetic services and supplies, a drug will not be covered if used solely for cosmetic purposes meant to enhance physical appearance. Also, drug quantity may be limited to specific amounts over certain periods. In these cases, your doctor may need to provide more information to ensure coverage conditions are met.

UMP Neighborhood may limit drugs to specific circumstances and protocols, or restrict initial and/or refill quantities where there is:

- Use outside the scope of this benefit;
- A sound clinical basis;
- Inadequate evidence of cost-effectiveness; or
- Evidence that cost-effectiveness is lacking.

Certain prescription drugs are subject to quantity limits, as indicated on the UMP Preferred Drug List. For some of these drugs, you may request an exception by having your pharmacist or prescribing provider call Express Scripts at 1-800-417-8164. This review is usually completed while your pharmacist or provider is on the phone with Express Scripts. If you're not satisfied with the review decision, you may appeal (see "Complaint and Appeal Procedures" starting on page 47).

Certain drugs in the categories listed below also may require a coverage review process for preauthorization. Check carefully whether the process applies to you or a family member by reviewing the specific criteria used to determine when coverage review is required. Note also that drug categories may be added or removed from this list throughout the year.

- *Growth hormone treatments*: Coverage may be allowed for 3- to 12-month renewable periods following authorization through the review process. Pediatric or adult hormone deficiency and AIDS wasting syndrome are covered conditions.
- *Acne treatment*: Patients ages 10-30 do not have to go through the review process; all others do.

To find out whether a certain drug is subject to review or quantity limits, or for specific questions on drug coverage management procedures or criteria, call Express Scripts at 1-866-576-3862, or visit the UMP Web site at **www.ump.hca.wa.gov**.

For preauthorization of injectable drugs that are not normally approved for self-administration, please call the UMP Neighborhood claims office at 1-888-380-2822.

What to Do if Coverage Is Denied

If a network pharmacy (including mail-service) informs you that coverage is denied or limited, or the prescription is otherwise not covered in full, your pharmacist or prescribing provider may contact Express Scripts at

1-800-417-8164 to begin the prescription drug coverage review process. A written determination will be sent to you and your provider within approximately two business days after your doctor has contacted Express Scripts with the information required to complete the coverage review.

If the medication is needed immediately, you may be eligible to receive a temporary supply during the review process. Ask your pharmacist to contact Express Scripts at 1-800-417-8164 for approval of a temporary supply.

See "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" on pages 31-32 and "Complaint and Appeal Procedures" starting on page 47 for additional information and procedures related to prescription drug coverage.

Covered Expenses

UMP Neighborhood benefits are payable only for medically necessary services and supplies provided in accordance with applicable medical review/preauthorization requirements, except for emergency care or as described for coordination of benefits with other health plans. (See "If You Have Other Medical Coverage" on pages 51-53.) Services must be received from an approved provider type (see list on pages 18-19).

In most circumstances, UMP Neighborhood follows Medicare coverage guidelines. All benefits are subject to the exclusions and limits shown in "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations" as well as in this section. Be sure to check "Definitions" for a description of most terms used in this *Certificate of Coverage*.

Most services are subject to the annual medical/surgical deductible. For details on the deductible and the annual medical/surgical out-of-pocket limit, as well as enrollee coinsurance and other cost-sharing, see "How UMP Neighborhood Works" and "Your Cost-Sharing Requirements."

Please note: Services received outside the state of Washington are covered only for urgent conditions and medical emergencies, or if you are referred by your care system provider for covered services that cannot be performed by a UMP PPO network provider. See exceptions for Medicare-enrolled retirees on pages 51-52 and for student dependents attending school outside the service area on page 7.

As described in the "Summary of Benefits" charts and "How UMP Neighborhood Works," your level of coverage depends on the provider you use and where you receive care.

Except when coverage is required by law, you will be liable for the costs of any services or supplies received after your UMP Neighborhood coverage ends.

The list of UMP Neighborhood covered expenses follows:

Acupuncture

This benefit covers acupuncture treatments or office visits to obtain acupuncture up to a combined total of 16 per calendar year. Acupuncture is covered only when used as an anesthetic or to reduce pain (not instead of surgery).

Ambulance

This benefit covers ambulance services for a life-threatening illness or injury, when other transport is not appropriate, to go:

- From the site of the medical emergency to the nearest facility equipped to treat a life-threatening illness or injury. See definition of medical emergency on page 73;
- From one facility to the nearest other facility equipped to give further treatment; or
- Home (if determined medically necessary).

Charges for regularly scheduled passenger air and rail transportation from the site of the medical emergency to the nearest facility equipped to provide the treatment are covered for the patient only—for one round trip per calendar year.

Ambulance services are reimbursed at 80% of UMP Neighborhood's allowed charge.

If ground ambulance services are not appropriate for transporting to the nearest facility, emergency air ambulance will be covered if the service meets the definition of medical emergency (page 73) and if air ambulance is the only appropriate method of transportation, based solely on UMP Neighborhood's determination of medical necessity.

If you frequently travel outside the U.S., you may want to purchase individual insurance for air ambulance services, as UMP Neighborhood covers this transportation only to the nearest facility equipped to provide the treatment needed. The fact you or your doctor prefer that you be transported to the facility nearest your home is not a consideration.

Biofeedback Therapy

Biofeedback therapy used to treat a physical medical condition, such as hypertension (high blood pressure), is covered at normal plan payment levels. If used for mental health treatment, biofeedback therapy is covered under the mental health payment provisions and subject to annual visit limits.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Blood and Blood Derivatives

Blood and blood derivatives, including but not limited to synthetic factors, plasma expanders, and their administration, are covered.

Bone, Eye, and Skin Bank Services

Biologic materials supplied by human bone banks, eye banks, and skin banks are covered.

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation that meet Medicare guidelines (not maintenance care) are covered when preauthorized.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment and supporting services, up to a maximum plan payment of $12,500 every 24 consecutive calendar month period. Chemical dependency is defined as an illness characterized by a physiological or psychological dependency on a controlled substance or on alcoholic beverages. For purposes of this benefit, treatment and services are medically necessary if recommended in the "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II" as published in 2001 by the American Society of Addiction Medicine. Chemical dependency does not include dependence on tobacco, caffeine, or food. Covered expenses include:

- Inpatient prescription drugs prescribed in connection with chemical dependency treatment (all other prescription drug charges are paid according to the provisions under "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies," starting on page 31).
- Inpatient treatment according to a prescribed provider plan at a hospital or substance abuse treatment facility, subject to approval by UMP Neighborhood's medical review program.
- Outpatient substance abuse diagnosis and treatment.

If you are not yet enrolled in a formal chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency and is not included in calculating the dollar maximum chemical dependency treatment benefit.

Dental Services

Routine and most other common dental services, including but not limited to dental extractions and aveoloplasties (regardless of the cause), are not covered as a UMP Neighborhood benefit. However, they may be covered by your PEBB dental plan. See excluded dental services on page 40.

General anesthesia and related facility charges are covered by UMP Neighborhood for any dental procedure performed in a hospital or ambulatory surgical center if the services are medically necessary because the enrollee:

- Is under the age of 7, with a dental condition that cannot be safely and effectively treated in a dental office;
- Is an individual with a physical or developmental disability whose dental condition cannot be safely and effectively treated in a dental office; or
- Has a medical condition the physician determines would place the enrollee at undue risk if the procedure were performed in a dental office (the procedure must be approved by the enrollee's physician).

General anesthesia means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide is not reimbursable as general anesthesia.

Services of a dentist are covered *only* for the following:

- Excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth, or restorative surgery required by the excision.
- Incision of salivary glands or ducts.
- Obturator maintenance for cleft palate, gum reduction for gingival hyperplasia due to Dilantin/phenytoin, or jaw reconstruction due to cancer.
- Preauthorized surgical treatment for temporomandibular joint (TMJ) conditions.
- Reduction of a fracture or dislocation of the jaw or facial bones.
- Repair of accidental injury to natural teeth, including evaluation of the injury and development of a treatment plan (services must be based on an evaluation and treatment plan completed within 30 days of the injury unless delay is medically indicated and the treatment plan is modified).

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Diabetes Education

This benefit covers a diabetes education program approved by Medicare or otherwise authorized by UMP Neighborhood. The benefit follows Medicare protocol and criteria for:

- Newly diagnosed diabetics.
- Diabetics whose treatment regimen is changed from diet control to oral diabetes medication, or from oral diabetes medication to insulin.
- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive HbA1c determinations three or more months apart in the year before training begins.
- Persons who are at high risk for complications from inadequate glycemic control including lack of feeling in the foot or other foot complications such as foot ulcers, deformities or amputation, preproliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes.

Diabetes education services must be prescribed by an approved provider type.

Diagnostic Tests, Laboratory, and X-Rays

This benefit covers:

- Diagnostic laboratory tests, x-rays (including diagnostic mammograms), and other imaging studies.
- Electrocardiograms (EKG, ECG).
- Electroencephalograms (EEG) and similar tests.
- Pathology exams.
- Screening and diagnostic procedures during pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders.
- Studies and exams to establish a diagnosis or monitor the progress and outcome of therapy.

These tests must be appropriate to the diagnosis or symptoms reported by the ordering provider.

Colonoscopies for enrollees age 50 or over will be covered under the preventive care benefit regardless of diagnosis.

Positron Emission Tomography (PET) scans require preauthorization.

Genetic testing requires preauthorization; genetic testing unrelated to pregnancy may be authorized only when performed by a specialist center/provider designated by UMP Neighborhood.

Charges for Magnetic Resonance Imaging (MRI) are covered when determined medically necessary *and* appropriate to diagnose a specific condition.

Screening mammograms in conjunction with a covered routine physical exam (subject to U.S. Preventive Services Task Force guidelines) are covered under the preventive care benefit.

In cases of alternative diagnostic approaches with different fees, UMP Neighborhood will cover the least expensive, medically reliable diagnostic method.

Electron Beam Tomography (EBT), self-referred or prescribed by your provider, is not covered.

Dialysis

Outpatient professional and facility services necessary for dialysis are covered when prescribed by an approved provider type to treat a covered condition. Independent dialysis facilities are covered at 80% of allowed charges. Dialysis facilities within a hospital or skilled nursing facility setting are reimbursed based on the network, non-network, or out-of network status of the hospital.

Durable Medical Equipment, Supplies, and Prostheses

Preauthorization of durable medical equipment for rentals more than three months or purchases over $1,000 is required.

This benefit covers services and supplies prescribed by an approved provider type to treat a covered condition, including:

- Artificial limbs or eyes (including implant lenses prescribed by a physician and required as a result of cataract surgery or to replace a missing portion of the eye).
- Breast pump for a medical condition of the mother or infant, such as a premature baby with difficulty sucking.
- Casts, splints, crutches, trusses, and braces.
- Contraceptive supplies that require a prescription, such as diaphragms.
- Diabetes care equipment (nondisposable) such as glucometers, insulin injection aids, and insulin pumps as well as accessories.
- Disposable diabetic supplies not purchased in a retail pharmacy or through our mail-service pharmacy.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

- Foot care appliances to prevent diabetes complications.
- Initial external prosthesis and bra required by breast surgery and replacement of these items when necessitated by normal wear, a change in medical condition, or additional surgery (also see "Mastectomy and Related Services" on pages 27-28).
- Ostomy supplies.
- Oxygen and rental equipment for its administration.
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication directly resulting from a covered surgery, or is a result of an injury to the genitalia or spinal cord *and* other accepted treatment has been unsuccessful.
- Rental or purchase (at UMP Neighborhood's option) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees cannot exceed full purchase price).
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of $100.

Equipment charges in excess of the charge for less costly equipment that serves the same medical purpose are not covered. It may help you to request preauthorization for frequently prescribed durable medical equipment items such as light boxes, hospital beds, and breast pumps. Otherwise, processing of these claims is suspended pending determination of medical necessity.

Note that durable medical equipment is covered at the network benefit rate only if you obtain the equipment or supply from a UMP PPO durable medical equipment supplier or other network provider.

Disposable supplies to treat diabetes purchased at a retail pharmacy or through our mail-service program are covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit starting on page 31. Prescription drugs used in conjunction with durable medical equipment are also covered under the "Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies" benefit.

Emergency Room

This benefit is subject to a separate $75 copay per visit in addition to your enrollee coinsurance and annual medical/surgical deductible. It covers emergency room services for diagnosis and emergency treatment of a covered illness or injury. If UMP Neighborhood determines emergency care is not medically necessary or could be rendered in a nonemergency setting with equal effectiveness, no benefits will be paid for emergency room services.

The emergency room copayment is waived if there is a direct hospital inpatient admission. However, the hospital inpatient services copayment or enrollee coinsurance will apply in these cases. See the "Summary of Benefits" for coinsurance/copayment details.

Hearing Care

This benefit is limited to $400 per enrollee in any 36 consecutive months. It covers:

- Hearing exams and evaluations related to the purchase of a hearing aid.
- Purchase of a hearing aid (monaural or binaural) prescribed as a result of the exam/evaluation, including:
  - Ear mold(s).
  - Hearing aid instrument.
  - Initial battery, cords, and other ancillary equipment.
  - Warranty and follow-up consultation within 30 days after delivery of hearing aid.
- Rental charges up to 30 days, if you return the hearing aid before actual purchase.
- Repair of hearing aid equipment.

To expedite claim payment for this benefit, submit the bills for the hearing exam and hearing aid purchase at the same time. Treatment for diseases/disorders of the ear or auditory canal (not related to a routine hearing exam) is covered as any other condition and not subject to the hearing care benefit limit.

Home Health Care

UMP Neighborhood preauthorization is required for home health care in which:

- Visits are daily;
- Visits are expected to exceed two hours a day; or
- Length of treatment is expected to last more than three weeks.

Reauthorization is required every two weeks unless otherwise approved by Medical Review. *Please call UMP Neighborhood at 1-888-759-4855 prior to the start of home health services in these cases.*

This benefit covers services provided and billed by a licensed home health agency to treat a covered illness or injury. Services must be part of a prescribed written

treatment program. The provider must certify that you are homebound and that hospital or skilled nursing facility confinement would be required in the absence of home health care. Covered expenses include:

- Ancillary services such as intermittent care (less frequently than daily visits, and under two hours per visit) from home health aides and clinical social services, provided in conjunction with the skilled services of an RN, LPN, or physical, occupational, or speech therapist.
- Disposable medical supplies as well as prescription drugs.
- Home infusion therapy.
- Visits for part-time or intermittent skilled nursing care and for physical, occupational, and speech therapy.

Hospice Care (Including Respite Care)

If preauthorized, hospice care provided by network providers is covered at 100% of allowed charges. If not preauthorized, the normal UMP Neighborhood benefit will apply.

This benefit covers hospice care for a terminally ill enrollee for up to six months. UMP Neighborhood may grant an extension if hospice care benefits have been exhausted. Services must be part of a written program of care developed by a state-licensed or Medicare-approved hospice.

The benefit includes:

- Inpatient services and supplies provided by the hospice, such as prescription drugs, medical supplies normally used for inpatients, and rental of durable medical equipment, when ordered by the attending provider.
- Respite care for a homebound hospice patient (continuous care of more than four hours a day to give family members temporary relief from caring for the patient), which is covered up to a $5,000 lifetime maximum.

Hospital Inpatient Services

This benefit covers hospital accommodation and the following inpatient services, supplies, equipment, and prescribed drugs to treat covered conditions:

- Blood and blood derivatives.
- Bone, skin, and eye bank services.
- Diagnostic tests and exams.
- General nursing care.
- Prescription drugs administered during an inpatient stay.
- Radiation and x-ray therapy.
- Surgery.
- Take-home prescription drugs dispensed and billed by the hospital upon discharge.

Inpatient physical, occupational, speech, and massage therapy requires preauthorization.

When the hospital has only private rooms, UMP Neighborhood will determine payment based on semiprivate room rates charged by other facilities in the area. Hospitals may bill you for the additional costs of certain high-cost services or devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples of services for which there may be additional charges include metal-on-metal or ceramic hip prostheses. Note that a *network* facility may not bill you for the difference between the standard service and the enhanced service, unless you agreed in writing to these charges prior to the service being provided.

In some cases, special-care unit accommodations, such as in a cardiac, intensive care, or isolation unit, may be covered based on the facility's special-care room rates.

Hospital Outpatient Services

This benefit covers services for outpatient surgery, day surgery, short-stay obstetrical services (discharged within 24 hours of admission), or observation services of less than 24 hours. It also includes outpatient ancillary services such as lab, x-rays, radiation therapy, IV infusion therapy, and physical, occupational, and speech therapy.

Mastectomy and Related Services

This benefit covers restorative surgery necessitated by previous surgery covered under UMP PPO or UMP Neighborhood as well as mastectomy necessitated by disease, illness, or injury.

An enrollee receiving benefits in connection with a mastectomy who elects breast reconstruction is covered for:

- Reconstruction of the breast on which the mastectomy was performed.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Physical complications of all stages of mastectomy, including lymphedemas.

Mental Health Treatment

This benefit covers hospital inpatient and outpatient services as well as professional services to treat neuropsychiatric, mental, or personality disorders, including eating disorders (bulimia and anorexia nervosa). Services from mental health providers for a mental health disorder are covered under this mental health treatment benefit, regardless of the cause of the disorder (such as postpartum depression).

Inpatient mental health treatment is limited to 10 days per calendar year. Outpatient mental health treatment is limited to 20 visits per calendar year. Visits for the sole purpose of medication management do not count toward the outpatient visit limit, and are instead covered as medical services.

As an alternative to inpatient care, UMP Neighborhood covers partial hospitalization services. With preauthorization, partial hospitalization services may count toward inpatient benefit limits at a rate of two partial hospitalization days per inpatient day, until the 10-day limit on inpatient services has been met. Partial hospitalization services (see page 75) will be considered outpatient services for determining applicable enrollee coinsurance. If you reach the 10-day limit for inpatient services, or if you do not obtain preauthorization, partial hospitalization services will count toward the 20-visit limit for outpatient services.

Marital, family, and sexual counseling are not covered. However, services of a licensed marriage and family counselor are covered when provided to treat neuropsychiatric, mental, or personality disorders.

Biofeedback therapy is covered under this benefit when prescribed as part of an overall treatment plan for a mental health condition.

Mental health treatment must be provided or directed by one of the following:

- Licensed community mental health agency.
- Licensed advanced registered nurse practitioner (ARNP) with training in psychology and counseling.
- Licensed physician.
- Licensed psychologist.
- Licensed Master of Social Work, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist.
- Licensed state hospital.

Services from non-PhD psychologists are covered under this benefit only when they are employed by and deliver services within a licensed community mental health agency *and* that agency bills for the services.

Although your care system may provide behavioral health services, you may also self-refer to a UMP PPO network mental health practitioner and receive coverage at the network level.

Mental Health Services and Your Rights

UMP and state law have established standards to:

- *Help ensure the competence and professional conduct of mental health service providers.*
- *Support your right to receive treatment only after informed consent.*
- *Protect the privacy of your medical information.*
- *Help you understand which services are covered under UMP Neighborhood and the limits on your coverage.*

For more information about covered mental health services, or if you have a question or concern about your mental health benefits, please contact UMP Neighborhood.

If you think any mental health benefit you have received from UMP Neighborhood may not conform to the terms of your coverage contract or your rights under the law, contact the UMP at 206-521-2000. If you have a concern about the qualifications or professional conduct of your mental health provider, call the Washington State Department of Health at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

Naturopathic Physician Services

This benefit covers services of a naturopathic physician. Herbs and other nonprescription drugs, lotions, vitamins, or minerals prescribed as part of naturopathic care are not covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Neurodevelopmental Therapy for Children Ages 6 and Younger

Children ages 6 and younger are covered for neurodevelopmental therapy to assist with motor or sensory skill, such as speech therapy for developmental disorders of articulation, language therapy to correct developmental language delay, or diagnosis or treatment of learning disabilities. Benefits are payable only where significant deterioration in the child's condition would result without such services, or to restore and improve the child's functions.

Inpatient therapy is subject to the hospital inpatient copayment or enrollee coinsurance and limited to 60 days per calendar year. Outpatient care is covered up to 60 visits per calendar year for all therapies combined.

This benefit includes only the services of UMP approved provider types authorized to perform the therapy. Licensed massage practitioners must be UMP network providers to be covered. Services must be part of a formal written treatment plan developed in consultation with the clinician diagnosing the condition and prescribing the therapy. The child is not eligible for both the "Physical, Occupational, Speech, and Massage Therapy" benefit and this benefit for the same type of services for the same condition, unless preauthorized by UMP Neighborhood as a case management benefit exception.

Obstetric and Newborn Care

Preauthorization is required for prenatal diagnostic screening for congenital disorders.

This benefit covers services for pregnancy and its complications when provided and billed by a licensed physician, nurse practitioner, licensed midwife or certified nurse midwife, hospital, or birthing center. Services must be determined necessary and appropriate by both the attending provider and the mother, based on accepted medical practice. Except in geographic areas where provider access is limited, the benefit includes only services provided by providers able to perform the full scope of obstetric services (prenatal, delivery, and postnatal care). Professional services include prenatal and postpartum care, prenatal testing (in accordance with standards set forth in WAC 246-680-020), vaginal or cesarean delivery, and care of complications resulting from pregnancy. Hospital services are covered for obstetric care subject to the inpatient hospital copayment or enrollee coinsurance. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this plan, and will not be subject to a separate copayment.

Newborn hospitalization for other than routine newborn care is covered subject to the hospital inpatient services copayment and/or enrollee coinsurance for the first 21 days from the date of birth, if the mother is covered by this plan.

Benefits for professional and other newborn follow-up care are also provided subject to any applicable deductible, copayment, or enrollee coinsurance amounts for the first 21 days from birth if the mother is covered by this plan. For newborn services beyond 21 days, the child must meet the plan's dependent eligibility as well as enrollment requirements, and any applicable premium must be paid.

For information on adding a new dependent to your coverage, see pages 57 or 65 (or call PEBB Benefit Services at 1-800-200-1004).

Services related to voluntary and involuntary termination of pregnancy are covered.

Office, Clinic, and Hospital Visits

This benefit covers visits involving face-to-face interaction between patient and provider for diagnosis or treatment of covered conditions.

Family planning services (including contraceptive supplies requiring a prescription or fitting, or surgical implantation/insertion of contraceptive devices such as IUDs, cervical caps, and long-acting progestational agents) are covered as well. See "Self-Referral for Women's Health Care" on page 16.

This benefit also includes visits by the surgeon, assistant surgeon, and anesthesiologist in performing:

- Cosmetic, plastic, and reconstructive surgery, including related services and supplies, if necessary to improve or restore bodily function lost due to a nonoccupational accident occurring while you're covered, or a congenital anomaly (such as cleft palate or spina bifida) in a covered dependent child.
- Elective sterilization (tubal ligation and vasectomy).
- Limited dental services (see page 24).
- Mastectomy and related covered benefits (see pages 27-28).
- Surgery for a covered condition.
- Restorative surgery necessitated by previous surgery covered under the UMP PPO or UMP Neighborhood.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Organ Transplants

Preauthorization is required for organ transplants. This benefit covers services related to organ transplants (bone marrow and stem cell are considered organs for purposes of this benefit), including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care. Donor expenses are covered as defined below. Related services such as outpatient prescription drugs, and outpatient laboratory and x-rays may be covered under other UMP Neighborhood benefits.

Organ transplants will be covered when they are preauthorized, are performed in a plan-designated facility, and meet all of the following criteria:

- The service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the service will directly improve the length or quality of the enrollee's life. Evidence is considered to be sufficient to draw conclusions if it is from published peer-reviewed medical literature (see definition on page 75), is well-controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
- The service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the enrollee that is more conservative or substantially less costly.

In addition, you must have been accepted into the treating facility's transplant program and continue to follow that program's protocol.

Costs to remove the organ from the donor and to treat complications directly resulting from the surgery are covered by the recipient's UMP Neighborhood coverage if the:

- Donor is not eligible for coverage under any other health care plan or government-funded program;
- Organ recipient is enrolled in UMP Neighborhood; and
- Organ transplant meets the above coverage criteria.

Benefit Limitations: Transplants are covered only if preauthorized and performed in a plan-designated facility (see definition on page 75). Coverage of direct medical costs for bone marrow, stem cell, and umbilical cord donor searches is limited to a combined total of 15 donor searches per transplant. No other benefits are provided for services related to locating an organ transplant donor.

Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)

This benefit covers services for outpatient surgery, day surgery, services at an ambulatory surgical center (ASC), or short-stay obstetric services (discharged within 24 hours of admission). *Depending on the procedure, a separate surgical suite/facility charge is not covered in some circumstances*. Although network providers cannot bill you for noncovered surgical suite/facility charges, you're usually responsible for these charges if billed by a non-network or out-of-network provider.

A doctor may be a network provider, yet perform services at a non-network day surgery/ASC. Be sure to confirm whether the facility is in your UMP Neighborhood care system prior to receiving services.

Phenylketonuria (PKU) Supplements

Phenylketonuria (PKU) supplements are covered when prescribed and used to treat PKU.

Physical, Occupational, Speech, and Massage Therapy

Inpatient physical, occupational, speech, and massage therapy must be preauthorized.

This benefit covers inpatient and outpatient services to improve or restore function lost due to:

- An acute illness or injury;
- An exacerbation of a chronic injury; or
- A congenital anomaly (such as cleft lip or palate) in a covered dependent child.

Inpatient rehabilitation therapy services are covered to a maximum of 60 days per calendar year subject to the hospital inpatient copayment and/or enrollee coinsurance. If UMP Neighborhood determines inpatient care is not medically necessary or could be received in an outpatient setting with equal effectiveness, no benefits will be paid for inpatient care.

Outpatient therapy services are covered to a maximum of 60 visits per calendar year for all therapies combined.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Services must be part of a formal written treatment plan developed in consultation with the clinician who diagnosed your condition and prescribed the therapy. Licensed massage practitioners must be UMP network providers to be covered. Massage therapy services exceeding one hour per treatment must be preauthorized.

UMP Neighborhood will not cover the same type of services for the same condition under both this benefit and the "Neurodevelopmental Therapy" benefit unless preauthorized as a case management benefit exception.

Prescription Drugs, All Insulin, and All Disposable Diabetic Supplies

This benefit covers legend drugs (those that can be legally obtained only with a written prescription) approved by the Food and Drug Administration (FDA) including:

- Allergy antigens.
- Chemotherapeutic agents for treatment of malignancies.
- Contraceptive drugs.
- Fluoride for prevention of dental caries in preschool children (see page 33).
- Injections of certain prescription medications.
- Methadone.
- Prenatal vitamins (during pregnancy).

Certain nonprescription drugs and supplies are also covered including:

- All insulin and all disposable diabetic supplies such as test strips, lancets, and insulin syringes used in the treatment of diabetes.
- Prenatal vitamins (during pregnancy).
- Nicotine replacement therapy (NRT) when recommended for participants in the *Free & Clear* tobacco cessation program.
- Over-the-counter products on the UMP Preferred Drug List (UMP PDL).

Insulin, prenatal vitamins, NRT, disposable diabetic supplies, and over-the-counter products on the UMP PDL are covered only when accompanied by a written prescription from an approved provider type.

To be covered, drugs must be prescribed and/or administered by a provider authorized by law to do so.

UMP Neighborhood prescription drug benefits are payable only for medically necessary medications and supplies. Services must be received from a licensed pharmacy employing licensed registered pharmacists.

Prescriptions from both retail pharmacies and our mail-service pharmacy are subject to the $100 per person annual prescription drug deductible.

The amount you pay varies based on the following three drug "tiers" (categories):

Tier 1: Generic drugs, all insulin, and all disposable diabetic supplies

Tier 2: Preferred brand-name drugs

Tier 3: Nonpreferred brand-name drugs

See "Your Prescription Drug Benefit Amount" and the "Summary of Benefits" for additional information on the tiers and specific cost-sharing requirements.

An FDA-approved drug used for off-label indications (that is, prescribed for a use other than its FDA-approved label) is covered only if recognized as effective for treatment:

- In a standard reference compendium (defined on page 76).
- In most relevant peer-reviewed medical literature (defined on page 75), if not recognized in a standard reference compendium.
- By the federal Secretary of Health and Human Services.

No benefits will be provided for any drug when the FDA has determined its use to be contraindicated.

Certain drugs may require preauthorization. In addition, UMP Neighborhood may limit medications to specific circumstances and protocols or restrict initial and/or refill quantities where there is:

- A sound clinical basis.
- Inadequate evidence of cost-effectiveness.
- Evidence of lack of cost-effectiveness.

See "Drug Coverage Management" on pages 21-22 for specific details.

You may receive up to a 90-day supply of medications at either a retail pharmacy or our mail-service pharmacy unless otherwise limited by the amount authorized by your prescriber, drug coverage management, preauthorization requirements, plan exclusions or limits, or drug availability. Specialty drugs (those that require special

handling or administration) are limited to a 30-day supply at retail pharmacies and a 90-day supply at our mail-service pharmacy.

Although in most cases you can receive up to a 90-day supply of your prescription drug, the actual supply depends on the provider prescribing the medication. If your provider orders less than a 90-day supply, the pharmacist cannot give you more. At mail-service, if your prescription is for less than a 90-day supply, your copayment will not be prorated.

See "Your Prescription Drug Provider Options" on page 16 for more information on your choice of pharmacies.

UMP Neighborhood has a preferred drug list, which for many drug classes is based on the Washington Preferred Drug List (Washington PDL) used by several state programs. This list was developed using evidence-based criteria for safe, effective, and appropriate prescribing. Your doctor may prescribe a preferred drug or any other drug he or she thinks is medically necessary for you. However, please note that the amount you pay for your prescription will depend on which tier it falls in (see page 17) and where you purchase it.

UMP retains the right to update the UMP Preferred Drug List (UMP PDL) or shift medications to different tiers during the year if generic or over-the-counter alternatives become available, or if there are changes to the Washington PDL or Express Scripts' National Formulary. UMP will notify enrollees about any changes to the UMP PDL or the Drug Coverage Management programs if these occur during the year.

In many drug classes, when your prescribing provider allows substitution on your prescription for a nonpreferred brand-name drug, your pharmacist may be required to substitute the UMP preferred drug. This is a requirement under a new state law that applies only to state-operated prescription drug programs (such as UMP) and prescribers who have endorsed the state's preferred drug list. You may ask your pharmacist to dispense the nonpreferred drug, but your out-of-pocket costs will be higher (Tier 3).

Mail-Service Pharmacy

You may order drugs by mail using our mail-service pharmacy, applying the same annual prescription drug deductible, preauthorization requirements, and limits as for retail prescription drugs.

Prescriptions mailed or orders placed in December, but not processed until January 1 or after, will be subject to the annual prescription drug deductible applicable **on the date the prescription is processed**. Due to increased volume at the end of the year, UMP cannot guarantee that prescriptions submitted to our mail-service pharmacy in December will be processed under the current benefit year.

If there is a manufacturer shortage of a specific drug (or other shortage that our mail-service pharmacy cannot control), and the quantity available is less than the quantity you ordered, the copayment will not be prorated. The original copayment applicable for up to a 90-day supply is charged.

Preventive Care

This benefit is not subject to the annual medical/surgical deductible. It covers the services in the tables that follow.

Benefits for well-baby care and routine physical exams for children and adults, including immunizations, were designed based on the U.S. Preventive Services Task Force guidelines, recommendations of the National Immunization Program of the Centers for Disease Control and Prevention, and recently published peer-reviewed literature on preventive care.

Services are provided on an outpatient basis specifically to monitor and maintain health and to prevent illness.

When received through your selected care system, the specified preventive care services shown in this section are covered at 100% of allowed charges (no deductible, coinsurance, or copayments).

If you receive preventive services that exceed those listed here, they will not be reimbursed under UMP Neighborhood's preventive care benefit. Instead, when medically necessary they will be reimbursed under the specific benefit the charges apply to (such as diagnostic tests, or laboratory and x-rays) and will be subject to the annual medical/surgical deductible. If your provider does not bill for a routine physical exam code and instead documents a diagnosis on your claim, the services are not considered preventive.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once in 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to the UMP in writing.

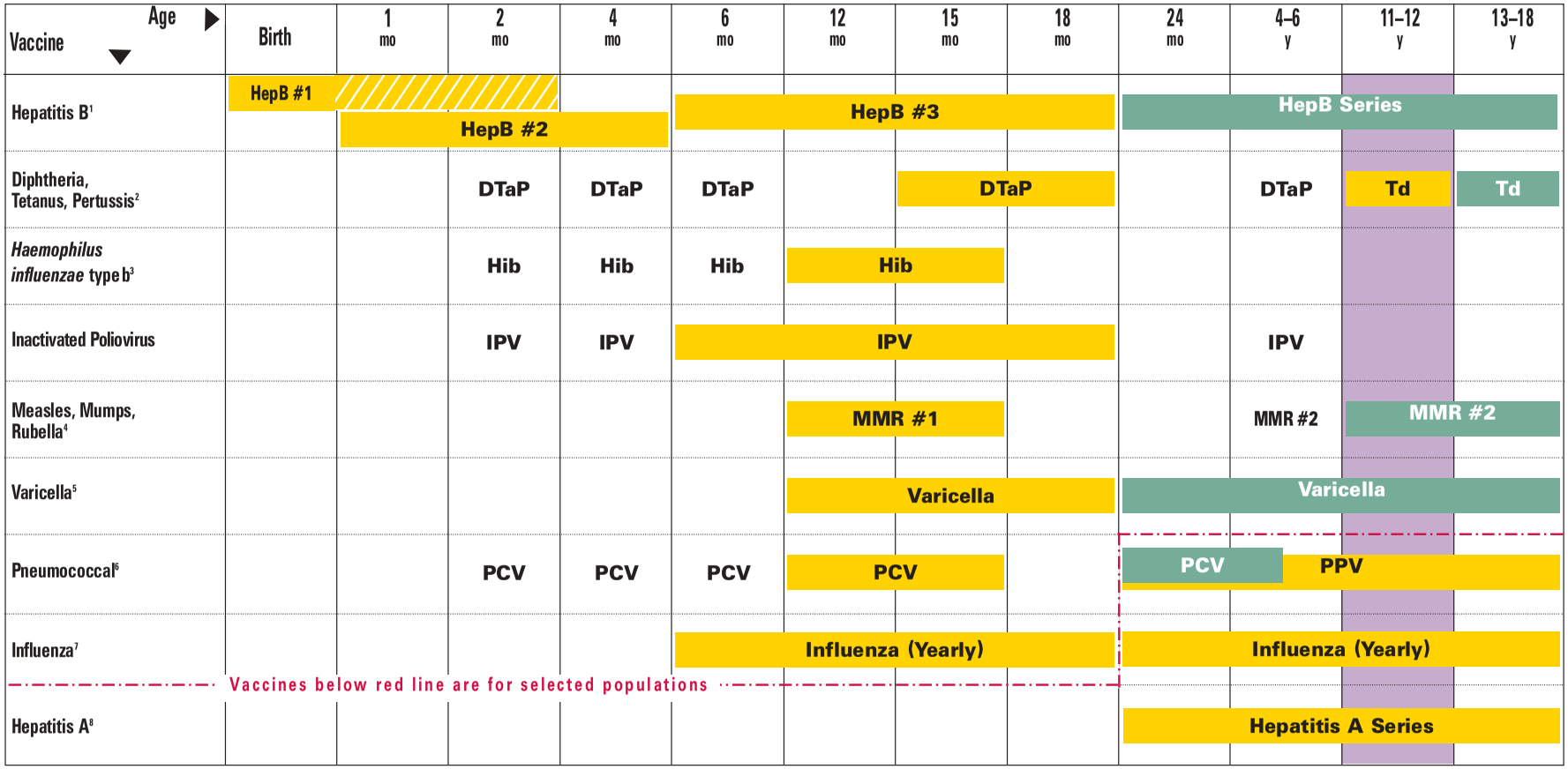
Children: Birth-6 years	
Screening exams	
Age	**Service covered**
2-4 days	Preventive health visit or home health visit, if your baby was discharged early.
Within 30 days	Preventive health visit.
2 months	Preventive health visit.
4 months	Preventive health visit.
6 months	Preventive health visit. Oral fluoride for preschool children older than 6 months if primary water source deficient in fluoride.
9 months	Preventive health visit with hemoglobin/hematocrit and/or lead screening if child at risk.
12 months	Preventive health visit.
15 months	Preventive health visit.
18 months	Preventive health visit.
2-6 years	Annual preventive health visit.

Children: Ages 7-18 years	
Screening exams	
Age	**Service covered**
8 years	Preventive health visit.
10 years	Preventive health visit.
11-18 years	Up to annual preventive health visit.
18 years	Females: Pap smear and chlamydia screening (earlier if sexually active).

The graph and explanation on the following pages represent the immunization schedule for children from birth to age 18 recommended by the National Immunization Program of the Centers for Disease Control and Prevention.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • JULY–DECEMBER 2004



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of April 1, 2004, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: *www.vaers.org* or by calling 800-822-7967.

- Range of recommended ages
- Only if mother HBsAg(-)
- Preadolescent assessment
- Catch-up immunization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
CDC SAFER·HEALTHIER·PEOPLE™

The Childhood and Adolescent Immunization Schedule is approved by:
Advisory Committee on Immunization Practices *www.cdc.gov/nip/acip*
American Academy of Pediatrics *www.aap.org*
American Academy of Family Physicians *www.aafp.org*

Footnotes

Recommended Childhood and Adolescent Immunization Schedule UNITED STATES • JULY–DECEMBER 2004

1. Hepatitis B (HepB) vaccine. All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9–15 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1–2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15–18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11–12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4–6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the visit at age 11–12 years.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons age ≥13 years should receive 2 doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children age 2–23 months. It is also recommended for certain children age 24–59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-35.

7. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, and diabetes), healthcare workers, and other persons (including household members) in close contact with persons in groups at high risk (see *MMWR* 2004;53;[RR-6]:1-40) and can be administered to all others wishing to obtain immunity. In addition, healthy children aged 6–23 months and close contacts of healthy children aged 0–23 months are recommended to receive influenza vaccine, because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons aged 5–49 years, the intranasally administered live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2004;53;[RR-6]:1-40. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if 6–35 months or 0.5 mL if ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

8. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

Preventive Care: Covered Services

When the preventive care tables that follow show the recommended frequency of service as once a year, annually, or every one to three years, coverage will not be provided more often than once every 12 consecutive months. Preauthorization to waive this requirement may be requested by describing your individual circumstances to the UMP in writing.

Men: Ages 19 Years and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
35-65 years	Blood cholesterol/lipids screening every 5 years.
50+ years	Fecal occult blood test for colorectal cancer at each preventive health visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of screening sigmoidoscopy.
50+ years	PSA (Prostate Specific Antigen) once a year at physician discretion.
65+ years	Preventive health visit once a year.
Immunizations	
Age or other indications	**Service covered**
19+ years	**Tetanus/Diptheria (Td) booster** once every 10 years.
19+ years	**Varicella** (if no history of chickenpox and not previously immunized).
19+ years	**Influenza vaccine**, annually.
College students, living in dormitories	**Meningococcal vaccine**, once.
40 years	**Measles/Mumps/Rubella (MMR)** second dose if not administered previously.
65+ years (or younger with chronic illness)	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Women: Ages 19 and Older	
Screening exams	
Age	**Service covered**
19-64 years	Preventive health visit every 1-3 years.
19+ years	Fasting blood glucose testing every 1-3 years for patients with established diagnosis of hypertension or established diagnosis of hyperlipidemia.
19-39 years	Pap smear and pelvic exam every 1-3 years after three yearly normal results (chlamydia screening through 24 years).
40+ years	Mammogram every 1-2 years depending on risk factors. Pap smears and pelvic exams every 1-3 years.
45-65 years	Blood cholesterol/lipids every 5 years; after age 65, at physician discretion based on risk factors.
50+ years	Fecal occult blood home test for colorectal cancer during each preventive care visit.
50+ years (or younger if at risk)	Flexible sigmoidoscopy once every 48 months. Colonoscopy once every 10 years, but not within 48 months of sigmoidoscopy.
65+ years	Preventive health visit once a year.
65+ years	Bone density screening using a combination of validated risk questionnaires and densitometry techniques every two years; may begin at age 60 if at risk.
Immunizations	
Age or other indications	**Service covered**
19+ years	**Tetanus/Diptheria (Td) booster** once every 10 years.
19+ years	**Varicella** (if no history of chickenpox and not previously immunized).
19+ years	**Influenza vaccine**, annually.
College students, living in dormitories	**Meningococcal vaccine**, once.
Childbearing age, but not during pregnancy	**Measles/Mumps/Rubella (MMR)** second dose (discuss with provider).
65+ years (or younger with chronic illness)	**Pneumococcal vaccine**—once; plus one-time revaccination five years later for patients with chronic illness or post-splenectomy patients.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Radiation and Chemotherapy

This benefit covers therapeutic application of radiation and chemotherapy.

Second Opinions

This benefit covers:

- Second opinions *required* under UMP Neighborhood's medical review/preauthorization or case management program (failure to obtain a second opinion when required may reduce your benefits by up to $200 or cause denial of benefits).
- Second opinions you *choose* to have, without UMP Neighborhood's requirements.

Except in an emergency, a second opinion is almost always a good idea before any major procedure or treatment program. The benefit of a second opinion may be greatest if you:

- Tell your attending physician you would like a second opinion.
- Try to get your opinion from a doctor unaffiliated with the first (preferably practicing at another institution).
- Consider seeking a second opinion on surgery from a non-surgeon.
- Let the second opinion provider know that you expect to have a thorough review of records, interview, and physical exam.

Required second opinions are covered at 100% of the allowed charge and are not subject to the annual medical/surgical deductible.

Skilled Nursing Facility

Preauthorization is required for inpatient skilled nursing facility benefits.

This benefit covers accommodations, services, and supplies to treat an accidental injury, illness, or other covered condition–when provided in and billed by a state-licensed, Medicare-certified skilled nursing facility.

You must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. Benefits are limited to 150 days per calendar year, unless UMP Neighborhood approves additional coverage in place of inpatient hospitalization.

Skilled nursing facility confinement for individuals with mental health conditions or retardation, or for care that is primarily domiciliary, convalescent, or custodial in nature is not covered.

Special Nursing Services

Acute skilled nursing services provided in the home or hospital by a nurse-level provider, and not received through a hospice or home health care agency, are covered to a maximum of $5,000 per person per calendar year.

Spinal and Extremity Manipulations

Manipulations of the spine or extremities, performed by a chiropractor, osteopathic physician, or other approved provider type, including related office visits and diagnostic tests/x-rays, are covered to a combined total of 10 visits per calendar year. (One or more of these services performed in a single encounter will count as one visit.)

Any diagnostic test, treatment, or x-ray required to diagnose or treat spinal subluxations or covered extremity disorders will be denied once the 10-visit limit has been reached.

Patient education or complementary and preparatory services are not separately reimbursed by UMP Neighborhood. UMP Neighborhood defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a spinal and extremity manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

Temporomandibular Joint (TMJ) Treatment

Surgical treatment for TMJ disorders is covered when preauthorized. Medical or dental treatment for TMJ disorders is not covered.

Tobacco Cessation Program

This benefit is covered in full and not subject to the annual medical/surgical deductible.

The benefit covers services by the *Free & Clear* tobacco cessation program only, which provides phone counseling and education materials. If nicotine replacement therapy, Zyban, or other drugs are advised by *Free & Clear* counselors, the prescription must be obtained from your provider and will be covered under the prescription drug benefit. These authorized prescription

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

drugs are not subject to the annual prescription drug deductible or enrollee coinsurance/copayment.

For more details or to enroll in the program, call 1-800-292-2336.

Tobacco or smoking cessation programs other than *Free & Clear* are not covered.

Vision Care (Routine)

This benefit is not subject to the annual medical/surgical deductible. It covers routine eye exams, including refractions, once every two calendar years.

An allowance of $100 toward prescription eyeglass lenses, frames, contact lenses, and fitting fees is provided every two calendar years and is not subject to enrollee coinsurance.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Expenses Not Covered, Exclusions, and Limitations

UMP Neighborhood covers only the services and conditions specifically identified in this *Certificate of Coverage*. Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-888-380-2822.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list.

1. Acupuncture, except as described under "Acupuncture" in "Covered Expenses."
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit (starting on page 32), such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. All procedures involving selection of embryo for implantation.
5. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
6. Autologous blood and its derivatives, including extraction or storage, except when used for a covered peripheral stem cell rescue procedure.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Convalescent or custodial care (intended primarily to assist in activities of daily living and not requiring continued services of skilled medical or allied health professionals).
11. Cosmetic services or supplies, including drugs and pharmaceuticals, except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly in a covered dependent child.
    - Restoring function.
12. Court-ordered care, unless determined by UMP Neighborhood to be medically necessary and otherwise within UMP Neighborhood's coverage criteria.
13. Dental care other than the specific covered dental services listed on page 24. For example, the following are not covered:
    - Any conditions not directly resulting from an accidental injury.
    - Any treatment of caries or gum disease (including, but not limited to, extractions or aveoloplasties), or other dental-specific services, regardless of the cause.
    - Dental implants.
    - General anesthesia and related facility charges, except as specified under "Dental Services" on page 24.
    - Malocclusion resulting from accidental injury.
    - Nitrous oxide.
    - Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction.
    - Orthodontic treatment.
    - Orthognathic surgery.
    - Treatment not completed within the time period established in the written treatment plan for an accidental injury.
    - Treatment of injuries caused by biting or chewing.
14. Dietary or food supplements, including:
    - Herbal supplements and homeopathic drugs;
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment;
    - Minerals; and
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).

15. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed in exclusion 42.
16. Educational programs, such as nutritional counseling for cholesterol control, or lifestyle modification programs, except diabetes education services as described on page 25; the *Free & Clear* tobacco cessation program described on pages 38-39; and medical nutrition therapy for the treatment of diabetes mellitus and chronic renal insufficiency, end-stage renal disease when dialysis is not received, or the medical condition of an enrollee within 36 months after kidney transplant.
17. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
18. Equipment such as:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Corrective shoes (except for diabetes).
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
    - Special or extra-cost features.
19. Experimental or investigational services, supplies, or drugs.
20. Foot care routine procedures, treatment of corns and calluses, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, or related prescriptions. (Foot care appliances for prevention or treatment of diabetes complications, however, are covered.)
21. Hearing care services or supplies such as:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP Neighborhood coverage ends.
    - Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.
22. Home health care such as:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Home Health Care" on pages 26-27.
    - Unless preauthorized:
      - Daily visits;
      - Visits exceeding two hours per day; or
      - Visits beyond three weeks.
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Maintenance or custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).
23. Homeopathic drugs, including prescription products.
24. Hospice care such as:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" on page 27, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).

25. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples include metal-on-metal or ceramic hip prostheses. See additional information under "Hospital Inpatient Services" on page 27.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and approved by UMP Neighborhood.
26. Immunizations, except as described under "Preventive Care" starting on page 32. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
27. Impotence or sexual dysfunction treatment with medications or pharmaceuticals.
28. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, or any other type of testing or treatment.
29. In vitro fertilization and all related services and supplies.
30. Learning disabilities treatment after diagnosis, including for dyslexia, except as described under "Neurodevelopmental Therapy" on page 29.
31. Maintenance therapy (see definition of maintenance care on page 73).
32. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" on page 38.
33. Marital, family, sexual, or other counseling or training services, except services provided by a licensed marriage and family therapist for neuropsychiatric, mental, or personality disorders.
34. Massage therapy, unless services meet the criteria in "Physical, Occupational, Speech, and Massage Therapy" under "Covered Expenses"; see pages 30-31. Services from massage therapists who are not UMP network providers, and services that exceed one hour unless preauthorized, are not covered.
35. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment" on page 28.
36. Missed appointments, billing fees, or completing or copying forms or records, except copying records to perform retrospective utilization review.
37. Non-network and out-of-network provider charges in excess of the plan's allowed charges (see page 70).
38. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric stapling, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition.
39. Organ donor coverage for anyone who is not a UMP Neighborhood enrollee, or for locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" on page 30.
40. Organ transplants or related services in nondesignated facilities, or transportation or living expenses related to organ transplants. See "Plan-Designated Facility" on page 75.
41. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" on page 39.
42. Out-of-state services that are not for urgent conditions or medical emergencies (except when your care system has notified UMP of a referral, Medicare is the primary payer, or for a covered student dependent attending school out of state).
43. Over-the-counter drugs, except the following products when prescribed by an approved provider type licensed to prescribe drugs:
    - Insulin;
    - Nicotine replacement therapy (while participating in the *Free & Clear* tobacco cessation program);
    - Over-the-counter products on the UMP Preferred Drug List; and
    - Prenatal vitamins during pregnancy.

44. Prescription drugs that have an over-the-counter equivalent product (identical active ingredients and strength) available in a comparable dosage form.
45. Recreation therapy.
46. Replacement of lost or stolen medications.
47. Residential mental health treatment programs or care in a residential treatment facility.
48. Reversal of voluntary sterilization (vasectomy or tubal ligation).
49. Services or supplies to the extent benefits are *available* under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered *available* if they are payable under that other policy, or would be payable if you or someone else made a claim for them and complied with that insurer's claim procedures.) However, UMP Neighborhood payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse UMP Neighborhood when settlement is received.
50. Services delivered by types of providers not listed as approved on pages 18-19, or by providers delivering services of a type or in a manner not within the scope of their licenses.
51. Services of a non-PhD psychologist, except when employed by and delivering services within a community mental health agency and that agency bills for such services.
52. Services or drugs related to tobacco use and smoking cessation, except as described under "Tobacco Cessation" in "Covered Expenses."
53. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" in "Covered Expenses" on page 27).
    - For which you are not obligated to pay.
54. Services or supplies, which are normally covered by Medicare, provided when Medicare is the primary payer and obtained through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
55. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see page 21 for details and exceptions).
56. Sexual disorder, diagnosis, or treatment.
57. Sexual reassignment surgery, services, counseling, or supplies.
58. Skilled nursing facility services or confinement for:
    - Individuals with mental health conditions or retardation.
    - Primarily domiciliary, convalescent, or custodial care.
59. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
60. Weight-loss drugs, services, or supplies.
61. Wilderness training programs for chemical dependency.

If you have questions about whether a certain service or supply is covered, call UMP Neighborhood at 1-888-380-2822 or 425-686-1218 in the Seattle area.

Filing a Claim

If Medicare is your primary coverage, please refer to "UMP Neighborhood Provisions for Retirees on Medicare" starting on page 51. UMP Neighborhood care systems and restrictions on out-of-state services may not apply to you.

If you need to submit a claim yourself, follow the steps below.

For services from providers not affiliated with your care system or not contracted with the UMP PPO network, submit a completed *Uniform Medical Plan Claim Form* to UMP Neighborhood at the address on the claim form. For prescription drugs from non-network pharmacies, submit a completed *Retail Prescription Drug Claim Form* to the address on the claim form. Forms are available from UMP Neighborhood or on the UMP Web site at **www.ump.hca.wa.gov**. Prescription drug claim forms are also available through Express Scripts Member Services at 1-866-576-3862, or on UMP's Web site at **www.ump.hca.wa.gov**.

When UMP Neighborhood is your primary payer (as defined on page 75), *network providers and network pharmacies will bill the plan for you.* (So even if you receive a bill from a network provider, since they're responsible for filing, don't submit the claim.)

Assembling Information

For medical services, your itemized bills should include:

- Patient's name and subscriber's identification number.
- Description of the illness or injury (usually a code number).
- Date and type of service.
- Provider's name, address, and fee.

The claim cannot be processed without this information. The *CMS 1500 Form* is the most common form used by providers to bill for professional services. Cash register receipts, balance due statements, or payment receipts can't be used to determine claim payments.

If you go to a non-network pharmacy, you must complete and sign a *Retail Prescription Drug Claim Form* for reimbursement. Pharmacy receipts alone are not acceptable for claim reimbursement unless they identify the drug name(s), date of purchase, dosage, and quantity of the drug as well as the pharmacy name and patient's name.

Submitting Your Claim

Claims from providers or pharmacies not affiliated with your care system or that do not contract with the UMP PPO network require submission of a completed *Uniform Medical Plan Claim Form* or *Retail Prescription Drug Claim Form*. Claims for insulin, disposable diabetic supplies, prenatal vitamins, over-the-counter drugs on the UMP Preferred Drug List, and nicotine replacement therapy (preauthorized by your *Free & Clear* counselor) must be accompanied by a copy of the prescription from an approved provider type.

Incomplete forms will be returned to you, which will delay the processing of your claim. If Medicare or another health plan is the primary payer on the claim, UMP Neighborhood may need to request the Explanation of Benefits statement issued by the other payer before we can finalize payment on the claim. Submit a separate claim for each person, although multiple medical services or retail prescriptions for the same person may be included on a single form. Do not use nicknames or initials on claim forms or bills. Keep a copy of all documents for your records, and send your medical/surgical claim (or any correspondence about your claim) to:

UMP Neighborhood
P.O. Box 34850
Seattle, WA 98124-1850

The *Retail Prescription Drug Claim Form* should be sent to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439

The plan will not pay claims submitted more than 12 months after the date of service.

See "Services Received Outside the U.S." on page 19 for additional instructions.

Explanation of Benefits (EOB)

An EOB is the detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

EOBs for medical/surgical services display each UMP Neighborhood claim submitted.

EOBs for retail prescription drugs purchased at a participating pharmacy will not be sent unless requested. If an EOB is necessary to coordinate benefits for retail drugs with other coverage, please call Express Scripts Customer Service at 1-866-576-3862, or visit UMP's Web site at **www.ump.hca.wa.gov** to access your private online pharmacy account.

For information on coordinating benefits with another health plan, see "If You Have Other Medical Coverage" on pages 51-53.

What Happens Next

Benefits are calculated according to UMP Neighborhood provisions. As described above, you will receive an EOB showing how each of your medical/surgical claims was processed. Be sure to keep the original EOB. You may need it for tax purposes or if there are any questions about payment to the provider.

Who Gets the Money When Claims Are Paid

If you use a network provider, UMP Neighborhood will send payments directly to the provider when the claim is processed. Therefore, you shouldn't pay a network provider for medical/surgical services until UMP Neighborhood has paid its part of the bill (unless you haven't met your annual medical/surgical deductible).

If you submit a claim for services from an out-of-network or non-network provider (other than a hospital), payment may be sent to you or to the provider, depending on your answer to "Have you paid for these charges?" on the claim form, the amount of reimbursement, and whether you assign payment to the provider. Claim payments for hospitals are almost always sent directly to the hospital, regardless of its status as a network, out-of-network, or non-network provider.

When payment goes to the provider, you and the provider receive an EOB detailing what services were covered and how benefits were calculated. Your EOB will have a check attached if payment is due to you.

If you submit claims for retail prescription drug purchases from non-network pharmacies, you will receive reimbursement by mail directly from Express Scripts following the processing of your claim.

If you have questions about filing a claim or the status of a claim, contact UMP Neighborhood Customer Service at 1-888-380-2822 or 425-686-1218 in the Seattle area.

Calculating Benefits When UMP Neighborhood Is Your Primary Coverage: Some Sample Claims

The following examples illustrate how benefits are calculated when UMP Neighborhood is the primary payer. Assume any annual deductible has been met, and any applicable out-of-pocket limit has not been reached.

Care system network provider:

Billed Charge	UMP Allowed Charge	UMP Neighborhood Pays	You Owe
$1,000	$900	$810 (90% x $900)	$90 ($900-$810)

Provider* who does not contract with UMP PPO, and to whom you self-refer outside your care system:

Billed Charge	UMP Allowed Charge	UMP Neighborhood Pays	You Owe
$1,000	$900	$540 (60% x $900)	$460 ($1,000-$540)

Out-of-network provider (see page 15) for urgent condition or medical emergency; OR Non-network provider (see page 15) that your care system provider referred you to:

Billed Charge	UMP Allowed Charge	UMP PPO Pays	You Owe
$1,000	$900	$720 (80% x $900)	$280 ($1,000-$720)

*Not applicable when Medicare is the primary coverage.

Complaint and Appeal Procedures

Complaints

What Is a Complaint?

A complaint is an oral or written expression of dissatisfaction submitted by or for an enrollee regarding:

- Denial of coverage or payment for health care services or prescription drugs;
- Issues other than denial of coverage or payment, including dissatisfaction, delays, or conflicts with UMP Neighborhood or providers; or
- Dissatisfaction with UMP Neighborhood practices or actions unrelated to health care services or prescription drugs.

Complaints on Medical or Surgical Matters

If you want to make a complaint other than one relating to prescription drugs, call 1-888-380-2822 or 425-686-1218 in the Seattle area from 8 a.m. to 6 p.m. Monday through Friday, or write UMP Neighborhood at:

UMP Neighborhood
Correspondence
P.O. Box 34578
Seattle, WA 98124-1578

Complaints to UMP Neighborhood regarding medical or benefit issues, providers, and availability of health care will be referred to the UMP Medical Review Department for consideration. If you have a complaint or concern about a health care provider (such as a complaint related to a provider's conduct or ability to practice medicine safely), please contact the Department of Health via e-mail at **hpqa.csc@doh.wa.gov** or 360-236-4700, or visit its Web site (**https://fortress.wa.gov/doh/hpqa1/disciplinary/complaint.htm**) for more information.

Complaints related to nonmedical problems will be referred to the customer service or claims manager depending on the specific concern. Most complaints can be resolved at this level.

If you submit a written complaint, UMP Neighborhood will send confirmation of receipt within five business days. You will also receive notice of the action on your complaint as soon as possible, or within 30 calendar days of receiving your complaint. UMP Neighborhood will notify you if additional time is needed for a response.

Complaints Relating to Prescription Drugs

If you are dissatisfied with issues related to your prescription drug benefit such as delays, customer service, or pharmacies, call Express Scripts at 1-866-576-3862, or communicate through UMP's Web site at **www.ump.hca.wa.gov**. Most complaints can be resolved at this level. But if your complaint cannot be resolved at this level, you may initiate an appeal within 180 days from the date the action occurred. See "First-Level Appeals" on the next page.

Prescription Drug Coverage Management

For certain drugs, UMP Neighborhood limits quantity or therapeutic uses for which a drug can be covered over a specific period. Your provider may request coverage for these medications in excess of UMP Neighborhood limits if medically necessary. If you are adversely affected by a limit on a prescription drug that is subject to coverage review (see pages 21-22), then your pharmacist or prescribing provider may call Express Scripts at 1-800-417-8164 to initiate drug coverage review for that particular medication. In some cases, your provider must contact Express Scripts before a decision can be made. You may be eligible for a temporary supply while the coverage review is in process. However, if you choose to receive the drug outside UMP Neighborhood's conditions, you will be responsible for the full cost of any medications for which coverage is denied.

Appeals

What Is an Appeal?

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP Neighborhood to reconsider:

- UMP Neighborhood's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP Neighborhood's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

You can also appeal decisions related to eligibility. Those include decisions where an adverse benefit decision is based on your not being eligible for coverage or not having paid premiums. Those appeals are handled separately. If your appeal involves those issues, call the Health Care Authority at 1-800-200-1004 or write to:

HCA Appeals Manager
P.O. Box 42699
Olympia, WA 98504-2699

General Information About Appeals

If you are appealing a decision to change, reduce, or terminate coverage for services already being provided, UMP Neighborhood is required to continue coverage for these services during your appeal. However, if the decision to change, reduce, or terminate coverage is upheld, you will be responsible for any payments made by UMP Neighborhood during that period. If you are appealing to request payment for denied claims or approval of services not yet initiated, UMP Neighborhood is not required to cover these services while the appeal is under consideration.

UMP Neighborhood will consult with a health care professional on appeals where the adverse benefit determination was based in whole or in part on a medical judgment. That includes decisions based on determinations that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The professional consulted in such a case will be one who has appropriate training and experience in the field of medicine involved. The professional will not be someone we consulted in making the earlier decision, or a subordinate of such a person.

Appeals may be filed by mail, fax, phone, or e-mail (send to **umpappeals@hca.wa.gov**).

You may send written comments, documents, and any other information to UMP Neighborhood when you appeal. You may also request copies of documentation UMP Neighborhood has that is relevant to your appeal, which will be provided at no cost. Our review will consider the information you submit to us, including material that was not considered in the initial benefit decision or earlier appeal. Our review will not assume the earlier decision was correct, and will be made by people who did not make the earlier decision and are not subordinates of anyone who did make the earlier decision.

Time Limits for UMP Neighborhood to Decide Appeals

The time limits below apply to both first- and second-level appeals, and are calculated from when UMP Neighborhood receives the appeal.

- The appeal decision will be made within 30 calendar days unless a shorter time limit applies as explained below. UMP Neighborhood will request written permission from you or your representative in cases where we recommend an extension to the 30-day timeline, in order to obtain medical records or a second opinion.
- In appeals involving a denial of a preauthorization request, the appeal decision will be made within 15 days.
- In a situation where delay could seriously jeopardize your life, health, or ability to regain maximum function, or where a physician who knows your condition tells UMP Neighborhood that delay would cause severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal, the appeal decision will be made as soon as possible but always within 72 hours (see "Expedited Appeals" below).
- If the adverse benefit decision was based on the conclusion that the service, drug, or device is experimental or investigational, the appeal decision will be made within 20 calendar days. If the appeal would otherwise have to be decided sooner than in 20 days, the shorter time limit applies.

Expedited Appeals

If your coverage is denied and your provider determines a delay in coverage would seriously jeopardize your life, health, or ability to regain maximum function, ask your provider to request an expedited appeal. All clinically relevant information should be submitted. The provider should contact UMP Neighborhood by phone, fax, or e-mail at:

Phone: 206-521-2000
Fax: 206-521-2001
E-mail: umpappeals@hca.wa.gov

First-Level Appeals

First-level appeals may be initiated orally or in writing no more than 180 calendar days after you receive notice of the action leading to the appeal. Although appeals may be made by phone or in person, putting them in writing with all of the necessary information will expedite the process.

First-Level Appeals for Medical or Surgical Matters

For medical or surgical appeals, UMP Neighborhood will send confirmation of receipt within five business days. Claim processing disputes will be reviewed by an experienced claims examiner who did not process the original claim. Appeals about covering, authorizing, or providing health care will be evaluated by a medical review nurse not involved in the initial determination to deny, reduce, modify, or terminate services or benefits. If the medical review nurse's recommendation is to uphold denial of coverage, or a decision is made not to authorize services because they have been determined to be experimental or investigational, or not medically necessary, the appeal will be further reviewed and decided by the UMP medical director or associate medical director.

For appeals involving medical or surgical matters, send first-level appeals to:

UMP Neighborhood
Medical Review
First-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 206-521-2001

First-Level Appeals for Prescription Drug Matters

You have the right to appeal if you or your provider disagrees with how your prescription drug claim was processed. That includes claims denial, reduction, or payment issues; applications of drug coverage management guidelines; medical necessity decisions; or drugs denied because of UMP Neighborhood benefit exclusions. To appeal a coverage denial from Express Scripts, you (or your provider on your behalf) can appeal orally or in writing within 180 calendar days of the date you received your notification of denial. In cases involving denial of coverage based on coverage review guidelines or medical necessity decisions, your provider should supply clinically pertinent information to Express Scripts. Therefore, it will expedite the process if your provider initiates these appeals for you.

For appeals involving prescription drug matters, send first-level appeals to:

Express Scripts, Inc.
Attn: Pharmacy Appeals: WA5
6625 West 78th Street
Mail Route BLO390
Bloomington, MN 55439

Fax: 1-877-852-4070
Non-Provider Phone Number: 1-866-576-3862
Provider Phone Number: 1-800-417-8164

Second-Level Appeals

Second-level appeals must be submitted within 180 calendar days of UMP Neighborhood's decision regarding the first-level appeal. Any additional information you have to support your appeal should be submitted with your request to appeal a determination. For second-level appeals, UMP Neighborhood will send confirmation of receipt within five business days.

Second-level **medical or surgical** appeals should be sent to:

UMP Neighborhood
Second-Level Appeal
P.O. Box 34578
Seattle, WA 98124-1578

Fax: 206-521-2001

Second-level **prescription drug** appeals should be sent to:

UMP Neighborhood
Prescription Drug Appeal
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001

The second-level review will be performed by the UMP Appeals Committee, consisting of the UMP executive director or designee, UMP medical director or associate medical director, and Director, Compliance and Enforcement, or designee.

Independent Review

You may request an external or "independent" review in two situations. You may request such a review of UMP Neighborhood's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service if UMP Neighborhood exceeds the timelines for response to your appeal without good cause and without reaching a decision. Also, you may request independent review even if UMP Neighborhood has met all timelines but you are dissatisfied with the determination of your second-level appeal. To have an external review, you must ask UMP Neighborhood to send you the forms that must be completed and returned to UMP Neighborhood. These forms authorize UMP Neighborhood to release your medical information to the independent review organization. This process is explained in the letter you receive in response to your second-level appeal, or you may call the Appeals Department at 206-521-2000.

To request the forms for an independent review by mail, fax, phone, or e-mail:

UMP Neighborhood
Independent Review Process
P.O. Box 91118
Seattle, WA 98111-9218

Fax: 206-521-2001
Phone: 206-521-2000
E-mail: umpappeals@hca.wa.gov

The "external review" will be done by an Independent Review Organization, or IRO. An IRO is a group of medical and benefit experts certified by the Washington State Department of Health and not affiliated with UMP Neighborhood in any way. An IRO is intended to provide unbiased, independent, clinical and benefit expertise as well as evidence-based decision making while ensuring confidentiality. UMP Neighborhood will pay the IRO's charges.

Any litigation against UMP Neighborhood must be brought in the Superior Court of Thurston County.

If You Have Other Medical Coverage

UMP Neighborhood coordinates benefits with any other group health plan covering you so that your UMP Neighborhood and other coverage combined will pay up to 100% of allowed charges (but not more than 100%). **Note:** This may result in your receiving one or more checks for "coordination of benefits (COB) adjustments" during the year. You receive this benefit adjustment because UMP Neighborhood benefits were available but not needed to pay on a claim your primary plan paid. Those saved UMP Neighborhood benefit dollars are later applied to the initial deductible or other, earlier enrollee cost-share expenses that you paid on other claims during that calendar year.

UMP Neighborhood coordinates benefits with the following types of plans:

1. Group or blanket disability insurance policies, and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations.
2. Labor management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans.
3. Governmental programs (including, but not limited to, Medicare, Medicaid, and workers' compensation) and coverage required or provided by any statute.

Benefits are not coordinated with any individual health coverage you have purchased, only with group plans. Also, this coordination of benefits provision does not apply to prescriptions filled through our mail-service pharmacy.

If you are covered by more than one health insurance plan, please submit claims to UMP Neighborhood and the other plan(s) at the same time. This helps to coordinate benefits more quickly.

The group insurance plan that is *primary* will process the claim first for all covered expenses. The primary plan will pay its normal plan benefit. The other plan(s) that cover you will be considered *secondary* and may pay less than their normal benefit, since total payments combined cannot exceed 100% of the allowed charges. When Medicare or another government program is one of the payers, federal law determines which plan provides benefits first. If you enroll in Medicare and are still an active employee, your Medicare coverage is secondary to UMP Neighborhood; Medicare becomes primary when you retire.

For retirees enrolled in Medicare, UMP Neighborhood is always secondary to Medicare for services covered by Medicare.

For coordination with plans other than Medicare, the following rules determine which plan is the primary payer:

- When both plans coordinate benefits, the plan covering the person as a subscriber pays first.
- Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are separated or divorced, the following rules determine which plan pays first, in this order:
  - Plan of the parent with custody;
  - Plan of the spouse of the parent with custody;
  - Plan of the parent without custody;
  - Plan of the spouse of the parent without custody.

However, if a court decree establishes responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If the rules above do not determine which plan is primary:

- The plan that has covered the *enrollee* for the longer period pays first.
- All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid off if the other plans follow this rule.

When none of the rules above determines which plan is primary, the plan that has covered the *subscriber* for the longer period pays first.

If UMP Neighborhood is the primary payer, UMP Neighborhood payment will be your normal UMP Neighborhood benefit.

UMP Neighborhood Provisions for Retirees on Medicare

Retirees entitled to Medicare must be enrolled in Parts A and B. UMP Neighborhood is not a Medicare supplement plan, as defined by the Washington State Insurance Commissioner.

Retirees dually enrolled in Medicare and UMP Neighborhood are not restricted to care system providers to receive the network level of benefits. Also, coverage is provided for Medicare retirees who receive covered non-urgent or non-emergent services outside of Washington State.

For services also covered by Medicare, claims from physicians who accept Medicare assignment are reimbursed at the network benefit level. Within Washington, Oregon and the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce, Medicare retiree claims for other services will be reimbursed at the network level if services are provided by UMP PPO network providers. If a non-network provider is chosen, reimbursement is at the non-network reimbursement level. In geographic areas within Washington and Oregon where there is no access to network providers as defined by UMP, or throughout the rest of the U.S. and outside the U.S., reimbursement is at the out-of-network level.

When Medicare coverage is primary, UMP Neighborhood does not cover charges for any services or supplies, which are normally covered by Medicare, obtained through a "private contract" with a physician or practitioner who does not provide services through the Medicare program.

Retirees enrolled in Medicare pay lower premiums because Medicare is the primary payer for most services. UMP Neighborhood assumes the primary payer role for services and supplies not covered by Medicare, such as most outpatient prescription drugs and certain preventive care services.

Special Reimbursement for Physicians Participating in Medicare

Non-network or out-of-network physicians who accept Medicare assignment are reimbursed at the network level when services are also covered by Medicare.

Coordination with Medicare

Benefits are coordinated with Medicare coverage in the same way as they are coordinated with other coverage.

In some cases, UMP Neighborhood will pay primary for retirees enrolled in Medicare when the service or supply is covered by UMP Neighborhood but not by Medicare, such as most prescription drugs.

Medicare-enrolled UMP Neighborhood enrollees may still be required to pay coinsurance and deductible amounts when Medicare deductibles have not been met, or when a service is not covered by Medicare. If a facility does not bill Medicare, coverage for such services may not be available under UMP Neighborhood if you are a Medicare-enrolled retiree. Call UMP Neighborhood Customer Service if you have questions regarding the status of your health care facility.

Coordination of benefits is managed in the same way for retirees as for active employees. When Medicare is primary, Medicare pays first and UMP Neighborhood pays second. Here's how the reimbursement process works under UMP Neighborhood's coordination of benefits:

- Medicare pays a portion of the bill. For all outpatient services in Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington, and Wyoming, the Part B Medicare administrator sends an electronic copy of each outpatient claim to UMP Neighborhood. You do not need to send a paper claim to UMP Neighborhood for your secondary benefit for these claims. For inpatient services, and for outpatient services in other states, Medicare sends you an Explanation of Medicare Benefits (EOMB) and you must send a copy of this to UMP Neighborhood.
- UMP Neighborhood identifies the difference between the Medicare allowed amount and the Medicare payment (the "remaining amount").
- UMP Neighborhood determines what the normal UMP Neighborhood benefit would have been if UMP Neighborhood had been the only insurer.
- UMP Neighborhood pays the remaining amount or the normal UMP Neighborhood benefit amount, whichever is less.

Here's an example to illustrate how this process works, assuming that your deductible has already been satisfied and you have received care in Washington from a network provider or a provider who accepts Medicare assignment.

Provider's charge	**$300**
Medicare Benefit Calculation	
Medicare allowed charge:	$100
Medicare pays:	$80 (80% of $100)
Remaining amount:	$20
UMP PPO Benefit Calculation	
UMP Neighborhood allowed charge:	$200
UMP Neighborhood normal benefit:	$180 (90% of $200)
UMP Neighborhood pays:	$20 (lesser of $20 or $180)
Enrollee Owes:	**$0**

In the example above, you owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with UMP or the primary plan as a network provider, you could be billed for the difference between the provider's actual charge and the highest of the plans' allowed charges.

When the Primary Payer is Other Than Medicare

When UMP Neighborhood is secondary to another group health plan or Medicare, standard coordination of benefits applies. However, for our mail-service pharmacy prescriptions, there is no coordination of benefits. This means that UMP Neighborhood is primary and pays first for all covered prescriptions purchased through our mail-service pharmacy, even if you have other coverage that is normally primary.

For other services, here's how it works when UMP Neighborhood is not the primary payer:

- The primary payer pays a portion of the bill and sends you an Explanation of Benefits (EOB); you send a copy of the bill and the EOB to UMP Neighborhood.
- UMP Neighborhood reviews the primary plan benefit calculation, and the primary plan payment.
- UMP Neighborhood determines what the normal benefit would have been if UMP Neighborhood had been the only payer.
- UMP Neighborhood compares allowed charges and determines which is the highest allowed charge.
- UMP Neighborhood pays the difference between the highest allowed charge and the primary plan's payment, up to the normal UMP Neighborhood benefit amount.

Here's an example to illustrate the process and terms above. This example assumes that the primary plan ordinarily pays 80% of allowed charges after a $500 deductible.

Provider's charge	**$1,200**
Primary Plan Benefit Calculation	
Primary plan's allowed charge:	$1,000
Primary plan deductible:	$500
Primary plan pays:	$400 (80% of $500 balance)
UMP Neighborhood Benefit Calculation	
UMP Neighborhood allowed charge:	$900
UMP Neighborhood deductible:	$200
UMP Neighborhood normal benefit:	$630 (90% of $700 balance)
Actual Payment by UMP Neighborhood	
Highest allowed charge: (primary plan)	$1,000
Primary plan's payment:	$400
UMP Neighborhood pays:	**$600**

In the example above, you owe nothing unless this is a provider who has not agreed to accept the highest allowed charge as payment in full. If a provider is not contracted with UMP or the primary plan as a network provider, you could be billed for the difference between the provider's actual billed charge and the highest of the plans' allowed charges.

Please contact UMP Neighborhood Customer Service at 1-888-380-2822 or 425-686-1218 in the Seattle area for assistance in answering any questions about benefits when you are covered by more than one plan.

Coordination of Benefits (COB) Questionnaire

You will receive a COB questionnaire from UMP Neighborhood every year. This provides UMP Neighborhood with information regarding other health care coverage. Failure to complete the form and return it to UMP Neighborhood may result in delay of claims payment. Please complete and return the form quickly.

When Another Party Is Responsible for Injury or Illness

UMP Neighborhood benefits are available if you're injured or become ill because of another party's action or omission, or if you have a work-related injury not covered by workers' compensation. UMP Neighborhood will be *subrogated* to your rights against any other party (including workers' compensation, and uninsured or underinsured motorist carriers, whether insured or self-funded) liable for payment for the illness or injury, which means UMP Neighborhood:

- Is entitled to reimbursement from any amount you recover from the other party, if you are fully compensated.
- Has the right to pursue claims for damages from the other party.

UMP Neighborhood's subrogation rights extend to the full amount of all benefits the plan paid for the illness or injury. As a condition of receiving benefits for the illness or injury, you and your representatives will cooperate fully with UMP Neighborhood in recovering paid amounts, including but not limited to:

- Providing facts to UMP Neighborhood about the illness or injury as well as the identity and address of the other party, his or her liability insurers and attorneys.
- Giving reasonable advance notice to UMP Neighborhood of any related trial, hearing, or intended settlement.
- Repaying UMP Neighborhood from the proceeds of any recovery.

More details on these responsibilities follow. (HCA/UMP Neighborhood rights in this section are in addition to any other remedies available under this *Certificate of Coverage* or otherwise provided by law.)

Your Obligation to Notify UMP Neighborhood

You must notify UMP Neighborhood in writing of any claim or lawsuit for an illness or injury for which the plan paid benefits, including:

- The facts of your illness or injury.
- Any changes in your illness or injury.
- The name of any person responsible for the illness or injury and their insurer.
- Advance notice of any settlement you intend to make.

Right of Recovery

If you bring a claim or lawsuit against another person, you also must seek recovery of any benefits paid under UMP Neighborhood; the plan reserves the right to join as a party. UMP Neighborhood may, however, recover benefits directly from you or the other person. If so, you don't need to take any action on behalf of UMP Neighborhood, but you must do nothing to impede the plan's right of recovery.

Right to Receive and Release Information

You may be required to give UMP Neighborhood or the HCA information necessary to determine eligibility, administer benefits, or process claims. This could include medical and other records. Coverage could be denied if you don't provide the information when requested.

False Claims or Statements

Neither you nor your provider (or any person acting for you or your provider) may submit a claim for services or supplies that were not in fact received, were resold to another party, or for which you are not expected to pay.

In addition, neither you nor any person acting for you may make any false or incomplete statements on any enrollment application under UMP Neighborhood.

The HCA may recover any payments made as a result of a false claim, false statement, or overpayment by UMP Neighborhood by withholding future claim payments or by other means.

Eligibility and Enrollment for Active Employees

Eligibility

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins)

Eligible Employees

Employees (referred to in this book as "employees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible to apply for coverage by PEBB plans in accordance with PEBB eligibility rules in Chapter 182-12 WAC. An employee is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person.

Eligibility for employees of participating employer groups may follow PEBB rules or rules determined by collective bargaining agreement, if approved by the HCA in accordance with Chapter 182-12 WAC.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. For example, a dependent child who is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one. The following dependents are eligible:

1. The subscriber's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. Dependent children through age 19. The term "children" includes the subscriber's biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the subscriber's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and additional legal dependents approved by the HCA are included. Dependent children beyond the age of 19 are eligible under the following conditions:
   a. Students age 20 through age 23 are eligible if they are registered at an accredited secondary school, college, university, vocational school, or school of nursing. To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to the HCA for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. When a student no longer meets eligibility criteria, the student's coverage will terminate on the last day of the month in which the loss of eligibility occurred. Misrepresentation or failure to notify PEBB of changes in status resulting in loss of eligibility, including changes in student status, may result in termination of coverage and the subscriber being responsible for payment of services received. Dependent student coverage continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the subscriber is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

Don't forget! Notify PEBB at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in loss of eligibility.

   b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred before age 20, or during the time they were covered under a PEBB plan as a registered student. For coverage to continue beyond the limiting age or loss of student eligibility, an application and proof of

disability must be submitted to the HCA for approval by UMP. The HCA will, on behalf of UMP, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber, (c) the subscriber who claimed the parent as a dependent continues enrollment in a PEBB program, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.
4. Dependents of an active employee who were previously covered under a K-12 or employer group medical plan, and who are not otherwise eligible for PEBB coverage, may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation, the PEBB plan must be immediately replacing a K-12 or employer group medical plan with no lapse in coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the HCA or UMP.

Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified same-sex domestic partners age 65 and older, the PEBB-sponsored medical plan will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to re-enroll in a PEBB medical plan offered to active employees. However, the employee will remain enrolled in PEBB-sponsored dental, life, and long-term disability coverage.

In most situations, employees and their spouses or qualified same-sex domestic partners can elect to defer Medicare Part B enrollment without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer and the PEBB-sponsored medical plan becomes secondary.

Please contact the HCA for information about retiree eligibility and benefit information.

Enrollment

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins)

Employees and their eligible dependents may enroll in this plan within 31 days of the date the employee first becomes eligible to apply for PEBB coverage as described in the "Eligibility" section. Enrollment forms are furnished by the employee's payroll, personnel, or insurance office and should be returned to that office within 31 days of the date of eligibility.

Notify your payroll office of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP Neighborhood benefits and helps us serve you better.

Eligible dependents who are not enrolled when they are initially eligible may be enrolled in the subscriber's PEBB medical plan if they lose coverage under another medical plan. Dependents losing other medical coverage must be enrolled within 60 days after termination of the other coverage, and provide proof of continuous coverage to the HCA to establish enrollment eligibility.

Eligible employees and dependents may enroll in PEBB coverage during any PEBB open enrollment period or if the employee acquires a new dependent as a result of marriage, qualified same-sex domestic partnership, birth, adoption, or placement for adoption. Eligible employees and dependents may enroll in these situations without proof of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Waiver of Coverage

Employees eligible for PEBB medical coverage have the option of waiving health plan coverage if they are covered by other health plan coverage. To waive coverage, the employee must complete an *Employee Enrollment/Change* form that identifies the individuals for whom coverage is being waived. If an employee waives coverage for him/herself, coverage is automatically

waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive coverage for any or all dependents.

An employee may only waive the medical portion of health plan coverage. The employee must remain enrolled in the dental, life, and long-term disability insurance coverages.

If PEBB medical coverage is waived, an otherwise eligible person may enroll in a PEBB plan only during the next open enrollment period, or within 60 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less.

The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 60 days after the date of marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption.

Enrolling a Dependent Acquired After the Subscriber's Effective Date of Coverage

Subscribers may enroll dependents who become eligible after the subscriber's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the subscriber should notify his or her personnel, payroll, or insurance office of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Subscribers should contact their personnel, payroll, or insurance office, or the HCA for an *Employee Enrollment/Change* form.

Disenrolling a Dependent

Employees should contact their payroll, personnel, or insurance office for forms and information on how to update their records. A dependent may be deleted from coverage by submitting an *Employee Enrollment/Change* form to the employee's personnel, payroll, or insurance office.

Please refer to the "Options for Continuing PEBB Benefits" section for more information.

Enrollment changes should be made as soon as possible. Eligibility changes not reported within 60 days after an event that creates a change in premium or loss of eligibility may result in a loss of premiums and a loss of the enrollee's right to continued coverage.

Failure to notify your payroll office or PEBB of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your dependent(s) were ineligible.

When Coverage Begins

Coverage will begin for employees and their dependents as follows:

For Employees

1. **Permanent Employees, Seasonal Employees, Career Seasonal/Instructional Employees:** Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.

2. **Nonpermanent Employees:** Coverage for nonpermanent employees begins on the first day of the seventh calendar month following the date of employment.

3. **Part-Time Faculty:** Coverage for part-time faculty begins on the first day of the month following the beginning of the second consecutive quarter/

semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

4. **Appointed and Elected Officials, Judges:** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

   Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

5. **Employees of Participating School Districts and Employer Groups:** The effective date of coverage for eligible employees may be determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

For Dependents

Coverage for eligible dependents begins on the day the subscriber's coverage begins if the subscriber lists the dependents on the application for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition or declaration. If the date of acquisition or declaration is the first day of a month, coverage will begin on the first day of the month of acquisition or declaration.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that the subscriber assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the HCA. If the condition of dependency is established and approved as of the first day of a month, coverage will begin on the date dependency is established.

Special Enrollment for Employees and Their Dependents Who Previously Waived Coverage

Coverage for eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll to enroll dependents.

1. Coverage for eligible employees and dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The application must be received by the employee's payroll, personnel, or insurance office within 60 days after termination of other medical coverage, and proof of other continuous comprehensive group medical coverage must be provided.
2. Coverage for eligible employees and dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership, will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.
3. Coverage for eligible employees and dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel, or insurance office within 60 days of the birth or date of placement.

Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 31 days of his or her move under the following

conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality, or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.

3. If a court order requires a subscriber to provide medical coverage for an eligible spouse or child, the subscriber may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the subscriber's effective date of coverage, whichever is later.
4. If a subscriber retires for any reason, the subscriber may change plans at the time of application for retiree coverage. The change will become effective on the first day of the month following the retirement date.
5. If an enrollee is covered under Medicare Part A and becomes enrolled in Medicare Part B, the enrollee may enroll in a Medicare Supplement Plan within six months of enrollment in Medicare Part B coverage.
6. Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.
7. If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 31 days after notification by the HCA. Anyone that does not choose another medical plan within this time period will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment (except for one of the reasons listed above).

To change plans, subscribers must fill out an *Employee Enrollment/Change* form. Subscribers should contact their payroll, personnel, or insurance office for forms and information on how to update their records.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP Neighborhood, the enrollee may not change health plans until the next open enrollment period. UMP Neighborhood cannot guarantee that any one physician, hospital, or other provider will be available and/or remain offered under the enrollee's care system. Also, if an employee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change health plans, except as outlined above.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.
2. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage) at midnight on the last day of the month in which the employee or dependent is eligible.
3. Premium payments are not prorated if an enrollee dies or terminates coverage prior to the end of the month.

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan which will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated at the end of the month in which the last full premium was received. **If the enrollee's coverage**

is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.

Options for Continuing PEBB Benefits

Employees covered by this plan have options for continuing coverage for themselves and their dependents during temporary or permanent loss of eligibility: (1) PEBB rules allow self-paid continuation of group coverage for up to 29 months during a temporary loss of pay; (2) the Family and Medical Leave Act of 1993 gives the enrollee the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks; (3) WAC 182-12-171 gives retired or permanently disabled employees and elected or appointed officials the right to enroll in retiree coverage; (4) the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives enrollees the right to continue group coverage for a period of 18 to 36 months; and (5) the enrollee has the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

Enrollees are not allowed to change medical plans at the time benefits are continued due to temporary loss of pay status or when the enrollee returns to active status. Enrollees will be allowed to change PEBB plans only as described in "Changing Medical Plans Mid-Year."

Continuing Coverage During Temporary Loss of Pay Status

When an employee temporarily loses pay status, PEBB group coverage may be continued at the group premium rate by self-paying premiums for a maximum of 29 months, except that part-time faculty may self-pay for group coverage between periods of active employee eligibility for a maximum of 18 months. If an employee is temporarily not in pay status for any of the following reasons, he or she may continue PEBB group coverage by self-paying the premium if:

1. The employee is on authorized leave without pay;
2. The employee is laid off because of a reduction in force (RIF);
3. The employee is receiving time-loss benefits under workers' compensation;
4. The employee is awaiting hearing for a dismissal action;
5. The employee is applying for disability retirement;
6. The employee is called to active military duty; or
7. The employee is on approved educational leave.

This 29-month period shall be reduced by the number of months of self-pay allowed under the federal COBRA law.

Employees who revert to a previously held position and do not regain pay status during the last month in which their employer contribution is made may continue their PEBB-sponsored medical coverage on the same terms as an employee who is approved for leave without pay.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

Enrollees must apply for coverage within 60 days after the date that employer-paid benefits end.

When an employee returns to work:

- For employees on an approved leave without pay, the employer contribution will be reinstated on the first of the month in which they return to eligible employment. Except in the case of approved family and medical leave, and except as otherwise provided, only employees in pay status eight or more hours per month are eligible to receive the employer contribution.

Family and Medical Leave Act of 1993

Employer contributions toward PEBB plan coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this period to maintain eligibility. After that, coverage may be continued as explained in the section titled "Continuing Coverage During Temporary Loss of Pay Status."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly fees hereunder are paid in full or in part by the employer, may pay the fees directly to the HCA if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by the HCA in writing, by mail addressed to the last address of record with the HCA, that the employee may pay the fees as they become due as provided in this section.

Surviving Dependents

If a dependent(s) loses eligibility due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. The

employee's spouse or qualified same-sex domestic partner may continue medical coverage until death; other dependents may continue medical coverage until they lose eligibility under PEBB rules. Surviving dependents must make application to enroll in PEBB coverage or defer the coverage, while enrolled in other comprehensive, employer-sponsored coverage or retirement from a federal retiree plan, within 60 days from the death of the employee. If a dependent does not receive a retirement benefit as described, see the "Options for Continuing PEBB Benefits" section.

Continuing Coverage Under the Federal COBRA Law

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments, employers are required (in most situations) to offer continuation of group coverage to enrollees losing eligibility for such coverage. When a "qualifying event" ends eligibility for coverage, the enrollee must contact the employee's payroll, personnel, insurance office, or the HCA at 360-412-4200 within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. If enrollees have the right to continue group coverage, they must submit an enrollment form within 60 days of the qualifying event. Enrollees are required to pay their own premiums, which begin accruing the first day of the month following the qualifying event. Failure to notify the payroll, personnel, insurance office, or the HCA may result in the loss of COBRA continuation privileges and retroactive denial of claims.

Qualifying events:

1. The employee and his or her covered dependents are entitled to continue PEBB-sponsored group coverage for up to 18 consecutive months if the qualifying event is: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second qualifying event during this 18-month period may extend the continuation period for dependents. Employees continuing their PEBB coverage under the federal COBRA law after termination of employment or reduction in hours, and who are disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage, can extend the continuation period an additional 11 months for all covered individuals. To qualify for the extended coverage, the HCA must be notified before the end of the initial 18 months of COBRA coverage and within 60 days of the disability determination.
2. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) the employee's death, (b) divorce, (c) election of Medicare as the employee's primary medical coverage, or (d) a child's loss of eligibility for dependent coverage.

COBRA subscribers may add eligible dependents in accordance with PEBB rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the month for which premiums have been paid in which the first of the following occurs:

1. The applicable continuation period expires;
2. The next required premium payment is not made when due;
3. The enrollee becomes covered under another group medical plan, unless the new plan contains a preexisting condition exclusion or limitation that applies to the enrollee (in which case COBRA coverage will cease on the earlier of [a] the end of the COBRA continuation period, or [b] the cessation of the application of the preexisting condition exclusion); or
4. The former employer ceases to offer group medical coverage.

When continued coverage ends, enrollees may apply for conversion to individual medical coverage as described in the "Conversion of Coverage" section.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise his or her COBRA continuation option.

Extension of Coverage for Covered Dependents Not Eligible for COBRA

The following dependents are eligible for an 18-month extension of coverage if the employee loses coverage due to one of the following events: (a) reduction of the employee's work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second event during this 18-month period may extend the continuation period for dependents up to a total of 36 consecutive months if the event is: (a) the employee's death, (b) termination of a qualified same-sex domestic partnership, (c) election of Medicare as the employee's primary medical coverage, or (d) a child's loss of eligibility for dependent coverage.

- Covered dependents of an employer group subscriber who do not meet PEBB dependent eligibility as defined in WAC 182-12-260.
- Qualified same-sex domestic partner.
- Children eligible through a qualified same-sex domestic partnership.

When an event ends eligibility for coverage, the enrollee must contact the employee's payroll, personnel, insurance office, or the HCA at 360-412-4200 within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. If enrollees have the right to continue group coverage, they must enroll within 60 days of the qualifying event, and will be required to pay their own premiums. Failure to notify the payroll, personnel, insurance office, or the HCA may result in the loss of continuation privileges and denial of claims back to the date of loss of eligibility.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group (including COBRA) coverage, or are not entitled to Medicare or another group coverage which provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group (including COBRA) coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of our conversion program differ from those of the enrollee's current group program. Enrollment in a conversion program may limit the enrollee's ability to later purchase individual coverage through carriers available in this state without health screening or a preexisting condition waiting period. To obtain detailed information on conversion options under this plan, call PEBB at 1-800-200-1004.

Eligibility and Enrollment for Retirees

Eligibility

(See "When Coverage Begins" to determine when coverage for eligible enrollees begins.)

Eligible Retirees

Retired or permanently disabled employees (referred to in this book as "retirees," "subscribers" or, in some cases, "enrollees") of state government, higher education, K-12 school districts, educational service districts, and employer groups are eligible for coverage by PEBB plans on a self-pay basis in accordance with Washington Administrative Code (WAC) 182-12-171. A retired or permanently disabled employee under WAC 182-12-171 is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more PEBB employers. A person enrolled in PEBB coverage as a subscriber cannot also be covered as a dependent on the PEBB plan of a spouse or other person. In order to be eligible, the following conditions must be met:

1. a. Under the following state of Washington retirement systems, individuals must immediately begin receiving a monthly retirement allowance, or have taken a lump-sum payment because their monthly benefit would be less than the minimum amount established by the Department of Retirement Systems:
    i. Public Employees Retirement System (PERS) 1, 2, or 3 (with the exception noted below in section 1.b.i.);
    ii. Teachers' Retirement System (TRS) 1, 2, or 3 (with the exception noted below in section 1.b.i.);
    iii. School Employees Retirement System (SERS) 2 or 3 (with the exception noted below in section 1.b.i);
    iv. Higher Education Retirement Plan (e.g., TIAA-CREF) (with the exception noted below in section 1.b.ii.);
    v. Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2;
    vi. State Judges/Judicial Retirement System; or
    vii. Washington State Patrol Retirement System (WSPRS) 1 or 2.

    b. Individuals in the following state of Washington retirement systems are not required to begin receiving a monthly retirement allowance, but may instead meet these conditions:
    i. Public Employees Retirement System (PERS) 3, Teachers' Retirement System (TRS) 3, and School Employees Retirement System (SERS) 3 not receiving a monthly retirement allowance (defined benefit), must be at least age 55 with at least 10 years of service credit at the time of separation;
    ii. Higher Education Retirement Plan (e.g. TIAA-CREF), must be at least age 55 with at least 10 years of service, or at least age 62.

    c. Employees who are approved a disability retirement must apply for coverage within 60 days after the date of the approval notice from the Department of Retirement Systems or their higher-education retirement system.

    d. Appointed and elected officials of the legislative and executive branches of state government who leave public office may continue their PEBB medical coverage on a self-pay basis whether or not they receive a retirement benefit from a state retirement system, provided they apply no later than 60 days after the end of their term.

2. All eligible retirees must submit an application to enroll or defer medical coverage **no later than 60 days** after their active employer or continuous COBRA coverage ends.

3. **Retirees and their covered dependents who are entitled to enroll in Medicare must enroll in Medicare Parts A and B.** A copy of their Medicare card must be provided to the Health Care Authority (HCA) as proof of enrollment. Enrollees not entitled to either Medicare Part A or B must provide HCA with a copy of the appropriate documentation from the Social Security Administration.

Deferring Coverage At or Following Retirement

If the retiree elects not to enroll in PEBB retiree coverage within 60 days after becoming eligible, or the retiree or his or her eligible surviving dependent(s) cancels their PEBB retiree coverage, the enrollee is not eligible for PEBB coverage unless he or she defers PEBB retiree coverage as outlined below.

Beginning January 1, 2001, a retiree may defer enrollment in PEBB medical coverage pursuant to WAC 182-12-205 if the following conditions are met. The retiree must be continually covered under another comprehensive, employer-sponsored medical plan as an active employee or as the spouse or qualified same-sex domestic partner of an active employee, or as a retiree or as the spouse or same-sex domestic partner of an employee's retirement coverage from a federal retiree plan.

Pursuant to WAC 182-12-200, a retiree whose spouse is enrolled as an eligible employee in a PEBB or Washington State K-12 school district-sponsored health plan may defer enrollment in PEBB retiree medical plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage.

To continue retiree term life coverage, coverage must be selected upon retirement and premiums must continue to be paid during the deferment period. To defer medical and dental coverage, the retiree must submit a PEBB enrollment form to the HCA indicating his or her desire to defer coverage. This must be accomplished prior to the date coverage is deferred, or within 60 days after the date he or she is eligible to apply for PEBB-sponsored retiree benefits.

Eligible Dependents

Eligible subscribers may enroll dependents in their PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans. The following dependents are eligible:

1. The retiree's lawful spouse or same-sex domestic partner (qualified through the declaration certificate issued by PEBB).
2. The retiree's dependent children through age 19. The term "children" includes the retiree's biological children, stepchildren, legally adopted children, children for whom the retiree has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, children of the retiree's qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as dependents of the retiree under the Internal Revenue Code and additional legal dependents approved by the HCA are included. Dependent children who are registered students or who are developmentally or physically disabled are eligible beyond the age of 19 under the following conditions:
   a. Students age 20 through age 23 are eligible if they are registered at an accredited secondary school, college, university, vocational school, or school of nursing. To certify and recertify eligibility, the subscriber must submit a *Student Certification/Change* form to the HCA for review, along with proof that the dependent is a registered student. Acceptable proof may include: i) current quarter/semester registration from the institution; or ii) past year report card/transcript from the institution. When a student no longer meets eligibility criteria, the student's coverage will terminate on the last day of the month in which the loss of eligibility occurred. Misrepresentation or failure to notify PEBB of changes in status resulting in loss of eligibility, including changes in student status, may result in termination of coverage and the subscriber being responsible for payment of services received. Coverage of dependent students continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the retiree is covered at the same time and the dependent has not reached age 24, and the dependent meets all other eligibility requirements.
   b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurred before age 20, or during the time they were covered under a PEBB plan as a registered student. For coverage to continue beyond the limiting age or loss of student eligibility, an application and proof of disability must be submitted to the HCA for approval by UMP. The HCA will, on behalf of UMP, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

Don't forget! Notify PEBB at 1-800-200-1004 as soon as possible of changes in student status. Such changes may result in loss of eligibility.

3. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous coverage in a PEBB-sponsored medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible retiree, (c) the retiree who claimed the parent as a dependent continues enrollment in a PEBB program, and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible retiree; however, dependent parents may not add additional family members to their coverage.

Verification of the dependency status of anyone enrolled under PEBB coverage may be requested at any time by the HCA or UMP.

Medicare Entitlement

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Office to inquire about Medicare enrollment.

Upon retirement, Medicare will become the primary coverage in most cases, and the PEBB-sponsored medical plan becomes secondary. PEBB plan enrollees retiring July 1, 1991, and after must be enrolled in Medicare Parts A and B, if entitled.

Please contact the HCA or the benefits office of the retiree's higher-education institution for information about retiree eligibility and benefit information.

Enrollment

Eligible retirees must submit an application to enroll in or defer PEBB coverage within 60 days from the date that their active employment or continuous COBRA coverage ends.

Retirees who deferred medical coverage while enrolled in other comprehensive, employer-sponsored coverage may enroll in this plan within 60 days of the date other employer-sponsored coverage ends or during a PEBB open enrollment period. Proof of continuous enrollment in comprehensive, employer-sponsored coverage is required with the application. Contact the HCA for information on the premiums and coverage available.

Retirees who defer PEBB medical and dental coverage while enrolled as a retiree or dependent in a federal retiree plan will have a one-time opportunity to re-enroll in PEBB medical and dental coverage. To re-enroll in PEBB medical and dental coverage, retirees or their surviving dependents must submit a *Retiree Enrollment/Change* form and proof of continuous enrollment in a federal retiree medical plan to the HCA either (a) during any PEBB open enrollment period, or (b) within 60 days after the date their other coverage ends.

An eligible subscriber may enroll dependents in his or her PEBB-sponsored medical plan if the dependent meets the criteria below. A dependent is eligible for coverage by only one PEBB-sponsored medical plan even if eligibility criteria are met under two or more plans.

Enrolling a Dependent Acquired After the Retiree's Effective Date of Coverage

Retirees may enroll dependents who become eligible after the retiree's effective date. Newly eligible dependents must be enrolled within 60 days after the date they become eligible.

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the retiree should notify the HCA or the benefits office of the retiree's higher-education institution of the birth, or the placement of the adoptive child, as soon as possible to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

3. Eligible dependents may be added during any PEBB open enrollment period without proof of continuous coverage.

Contact the HCA for an enrollment/change form.

Special Enrollment Period for Dependents

Coverage for eligible dependents whose medical coverage was previously waived will be effective as described below.

1. Eligible dependents who were waived **while the retiree maintained enrollment in a PEBB**

medical plan may be enrolled during any PEBB open enrollment period, or within 60 days of loss of other medical coverage. Outside of enrollment during a designated open enrollment, proof of other medical coverage is required to demonstrate that: 1) coverage was continuous; and 2) the period between loss of coverage and application for PEBB coverage is 60 days or less. Coverage for eligible dependents enrolling because of loss of other medical coverage will begin on the first day of the month following the date the prior coverage terminated. The application must be received by HCA within 60 days after termination of other medical coverage. Coverage for eligible dependents enrolling during a PEBB open enrollment period will begin January 1 of the following year.

2. Retiree's marriage or qualified same-sex domestic partnership: Coverage for eligible dependents enrolling following a marriage or establishment of a qualified same-sex domestic partnership will begin on the first day of the month following the date of marriage or the date that the same-sex domestic partnership qualifies based on the declaration. If the date of marriage is the first calendar day of the month, coverage will begin on the date of marriage. The application for coverage must be received by the HCA within 60 days after the date of marriage or date that the same-sex domestic partnership qualifies based on the declaration.
3. Birth or adoption: Coverage for eligible dependents enrolling following a birth or placement of a child for adoption will begin on the first day of the month in which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the HCA within 60 days of the birth or date of placement.

Disenrolling a Dependent

Retirees should contact the HCA to update their records. A retiree may delete a dependent by submitting an enrollment/change form to the HCA. Failure to notify PEBB of changes in status resulting in loss of eligibility may result in termination of coverage and the subscriber being responsible for payment of services received. Please refer to the "Options for Continuing Benefits" section for more information.

Enrollment changes must be submitted to the HCA within 60 days after the event that created the change.

Notify HCA at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your UMP Neighborhood benefits and helps us serve you better.

When Coverage Begins

Coverage for eligible retirees begins on the day following loss of other coverage provided application for retiree coverage is made in accordance with PEBB rules.

Coverage for eligible dependents begins on the day the retiree's coverage begins if the retiree lists the dependents on the application for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with PEBB rules, coverage begins on the first day of the month following the date of acquisition/declaration. If the date of acquisition/declaration is the first day of a month, coverage will begin on the first day of the month of acquisition/declaration.

Coverage for a newborn child begins at birth.
Coverage for an adoptive child begins on the date that the retiree assumes a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the first of the month following the date the condition of dependency is established and approved by the HCA. If the condition of dependency is established and approved on the first day of a month, coverage will begin on the date dependency is established.

Changing Medical Plans Mid-Year

Enrollees may change medical plans in the following situations:

1. During a PEBB open enrollment period.
2. If an enrollee changes residence during the plan year, he or she may change plan enrollment within 31 days of his or her move under the following conditions: if an enrollee moves from his or her plan's service area, he or she may enroll in any plan available in his or her new locality; or if a plan has not been available to the enrollee and he or she moves into that plan's service area, he or she may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a retiree to provide medical coverage for an eligible spouse or child, the retiree may change medical plans and add the dependent

immediately, with the change effective retroactive to the effective date of the court order or the retiree's effective date of coverage, whichever is later.

4. If an enrollee is covered under Medicare Part A and becomes enrolled in Medicare Part B, the enrollee may enroll in a Medicare Supplement Plan within six months of enrollment in Medicare Part B.

5. If a retiree's medical plan becomes unavailable, the retiree may choose another medical plan within 31 days after notification by the HCA. Anyone who does not choose another medical plan within this time period will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the UMP PPO may not change medical plans until the next open enrollment (except for one of the reasons listed above).

To change plans, the retiree must fill out a *Retiree Enrollment/Change* form. Retirees should contact the HCA or the benefits office of their higher-education institution to update their records.

If you move out of the UMP Neighborhood service area (King, Pierce, and Snohomish counties) during the plan year and choose to enroll in UMP PPO, any amounts paid or services received as a UMP Neighborhood enrollee will not count towards the UMP PPO deductibles, benefit limits, or annual out-of-pocket limit. New deductibles, benefit limits, and out-of-pocket limit will apply (see pages 5-6), and your monthly premium will increase as of the date of coverage under UMP PPO.

Note: Your contractual relationship is with the health plan you have selected, not the individual providers available through the health plan. If an enrollee's provider or health care facility discontinues participation with UMP Neighborhood, the enrollee may not change health plans until the next open enrollment period. UMP Neighborhood cannot guarantee that any one physician, hospital, or other provider will be available and/or remain offered under the enrollee's care system. Also, if an employee transfers from one agency or school to another during the plan year, the enrollee is not permitted to change health plans, except as outlined above.

When Coverage Ends

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB plan.

2. If the retiree stops paying monthly premiums, coverage ends for the retiree and dependents on the last day of the month for which the last **full premium** was paid. A full month premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or terminates prior to the end of a month.

3. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20, or a spouse when a final decree of divorce is entered).

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, benefits will be extended until:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted, whichever occurs first.

When coverage ends, the enrollee may be eligible for continuation of coverage or conversion to other health care coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums and reporting of changes in eligibility or address.

As a PEBB plan enrollee, it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's coverage will be terminated

the end of the month in which the last full premium was received. **If the enrollee's coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB program will end.**

The enrollee and his or her covered dependent(s) or beneficiary is responsible for reporting changes within 60 days after the event, such as divorce, death, or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of your or your dependents' right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the HCA, please call PEBB Benefit Services at 1-800-200-1004.

Options for Continuing PEBB Benefits

Some enrollees covered by this plan who lose eligibility have options for continuing coverage: (1) PEBB rules allow for continued retiree coverage of dependents of a deceased subscriber, (2) the federal COBRA law gives enrollees the right to continue group coverage for a period of 18 to 36 months, and (3) the enrollee has the right of conversion to individual medical coverage when continuation of group medical coverage is no longer possible. The dependents of retirees also have options for continuing coverage for themselves following loss of eligibility.

Retirees and permanently disabled employees of employer groups whose participation in a PEBB plan ends may be eligible to continue PEBB retiree coverage for only the 18-month period authorized by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Continuing Retiree Coverage Under PEBB Rules

Dependents who lose eligibility due to the death of a PEBB-eligible retiree may continue coverage under this retiree plan. The retiree's spouse or qualified same-sex domestic partner may continue coverage until death; other dependents may continue coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days from the death of the retiree.

Eligible surviving dependents of a deceased retiree who are not enrolled in PEBB coverage at the time of the retiree's death must apply to enroll in PEBB coverage or defer coverage (while enrolled in comprehensive, employer-sponsored coverage, or retirement coverage from a federal retiree plan) within 60 days of the date the retiree died.

Enrollees should contact the HCA for an enrollment form.

Continuing Retiree Coverage Under the Federal COBRA Law

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments, employers are required (in most situations) to offer continuation of group coverage to enrollees losing eligibility for such coverage. When a "qualifying event" ends eligibility for coverage, the enrollee must contact the HCA or the benefits office of the retiree's higher-education institution within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. If enrollees have the right to continue group coverage, they must submit an enrollment form within 60 days of the qualifying event. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. Failure to notify the HCA or the benefits office of the retiree's higher-education institution may result in the loss of COBRA continuation privileges and retroactive denial of claims. Qualifying events:

1. The retiree and his or her covered spouse and dependent children are entitled to continue PEBB-sponsored group coverage for up to 18 consecutive months if the qualifying event is: (a) the retiree ceases to qualify for disability retirement, or (b) the retiree retired from an employer group that began participation in PEBB-sponsored benefits after September 15, 1991, as defined in WAC 182-12-111(2), and the employer group terminates participation in the PEBB program. A retiree continuing his or her PEBB coverage under the federal COBRA law who is disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage can extend the continuation period an additional 11 months for all covered individuals. To qualify for the extended coverage, the HCA must be notified before the end of the initial 18 months of COBRA coverage and within 60 days of the disability determination.
2. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) divorce, or (b) a child's loss of eligibility for dependent coverage.

Each of the retiree's enrolled dependents is entitled to make a separate decision to exercise his or her COBRA continuation option.

COBRA subscribers may add eligible dependents in accordance with PEBB rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the month for which premiums have been paid in which the first of the following occurs:

1. The applicable continuation period expires;
2. The next required premium payment is not made when due;
3. The enrollee becomes covered under another group medical plan, unless the new plan covering the enrollee contains a preexisting condition exclusion or limitation that applies to the enrollee (in which case COBRA coverage will cease on the earlier of [a] the end of the COBRA continuation period, or [b] the cessation of the application of the preexisting condition exclusion); or
4. The former employer ceases to offer group medical coverage.

When COBRA coverage ends, enrollees may apply for conversion to individual medical coverage as described in the "Conversion of Coverage" section.

Extension of Coverage for Covered Dependents Not Eligible for COBRA

The following dependents may continue PEBB coverage for up to a total of 36 consecutive months if they lose PEBB coverage due to: (a) termination of a qualified same-sex domestic partnership, or (b) loss of dependent child eligibility.

- Qualified same-sex domestic partner.
- Children eligible through a qualified same-sex domestic partnership.

When an event ends eligibility for coverage, the enrollee must contact the HCA within 60 days of the qualifying event for information about the right to an extension of coverage and self-pay premium rates. Enrollees are required to pay their own premium, which begins accruing the first day of the month following the qualifying event. Failure to notify the HCA will result in the loss of continuation rights.

Each of the retiree's enrolled dependents is entitled to make a separate decision to exercise this continuation option.

Conversion of Coverage

Enrollees have the right to switch from PEBB group (including COBRA) medical coverage to an individual conversion plan offered by UMP when they are no longer able to continue PEBB group coverage, or are not entitled to Medicare or another group coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their PEBB group (including COBRA) coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage, and eligibility requirements of the conversion program differ from those of the enrollee's current group program. Enrollment in a conversion program may limit the enrollee's ability to later purchase an individual plan without health screening or a preexisting condition waiting period. To obtain detailed information on conversion options under this plan, call PEBB at 1-800-200-1004.

Definitions

Adverse Benefit Determination

A denial, reduction, or termination of payment, coverage, or authorization for a benefit. It includes a failure to make a payment (in whole or in part) for a benefit.

Allowed Charge(s)

The maximum amount UMP Neighborhood allows for a specific covered service or supply. For professional services, durable medical equipment, supplies, and prostheses, allowed charges are the lesser of the provider's billed charge or:

- For *network* providers, the applicable contracted fee schedule amount.
- For *non-network/out-of-network providers* **in Washington**, the UMP fee schedule amount.
- For *non-network/out-of-network providers* **outside of Washington**, a regionally adjusted charge (defined on page 76).

Note: The UMP fee schedule identifies certain services/procedures that are reimbursed on a case-specific (by report) basis. In this instance, the allowed charge may be based on UMP's fee schedule amounts for comparable services/procedures, billed charges (or percent of billed charges), Medicare's fee schedules, rates negotiated by case managers, and/or other method(s) at UMP Neighborhood's discretion.

Allowed charges for services from network hospitals and other facilities are determined by the provider's contract with UMP. For services from non-network or out-of-network facilities, allowed charges are generally based on the provider's billed charge, unless other arrangements have been made.

Allowed charges for prescription drugs are based on Express Scripts' standard reimbursement terms for its network pharmacies, unless other contractual arrangements or terms apply.

The UMP Neighborhood fee for most drugs and biologicals administered other than orally by a provider is based on a percentage of the Average Wholesale Price (AWP) or a percentage of the Average Sales Price (ASP) determined by the Centers for Medicare & Medicaid Services.

UMP Neighborhood reserves the right to determine the amount payable for any service or supply.

Ambulatory Surgical Center (ASC)

A facility certified by Medicare or accredited by an accreditation organization recognized by the Centers of Medicare & Medicaid Services (such as the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), that provides services for patients who receive invasive procedures requiring general, spinal, or other major anesthesia. (Examples of invasive procedures are biopsies, cardiac and vascular catheterizations, and endoscopies.) The ASC must be licensed by the state(s) in which it operates, unless that state does not require licensure.

Annual Medical/Surgical Deductible

A dollar amount you must pay each calendar year before UMP Neighborhood pays medical/surgical benefits. Except for services specifically exempted in the "Summary of Benefits," the first $200 per individual in allowed charges for medical/surgical services (or $600 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual medical/surgical deductible and are your responsibility.

Annual Medical/Surgical Out-of-Pocket Limit

A dollar limit on the enrollee coinsurance and copayments you must pay for medical/surgical services each calendar year. The annual limit on the amount you are required to pay in coinsurance and copayments for medical/surgical services (in addition to your annual medical/surgical deductible) is $1,125 per individual or $2,250 per family. Once you have reached this limit, most claims from network and out-of-network providers are paid at 100% of allowed charges, except as otherwise specified in this *Certificate of Coverage*. For additional information see pages 5-6 of this document. The following services and charges are *not* counted towards your or your family's annual medical/surgical out-of-pocket limit:

- Annual medical/surgical and prescription drug deductibles.
- Benefit reductions for failure to comply with medical review/preauthorization requirements.
- Charges beyond benefit maximums, limits, and allowed charges.
- Charges for expenses not covered.
- Copayments for emergency room care.
- Enrollee coinsurance/copayments for retail and our mail-service prescription drugs.
- Enrollee coinsurance/copayments for non-network services (see page 15 for definition of non-network reimbursement).

Annual Prescription Drug Deductible

A dollar amount you must pay each calendar year before UMP Neighborhood pays prescription drug benefits. The first $100 per individual in allowed charges for prescription drugs (or $300 per family if three or more family members are enrolled on one subscriber's account) apply toward your annual prescription drug deductible and are your responsibility.

Appeal

An appeal is an oral or written request submitted by an enrollee or his or her authorized representative for UMP to reconsider:

- UMP's adverse decision regarding a complaint;
- A claim processing issue; or
- UMP's decision to deny, modify, reduce, or terminate payment, coverage, or authorization for health care services or prescription drugs.

Eligibility for enrollment in UMP Neighborhood coverage is determined by PEBB.

Approved Provider Types (or Approved Provider)

See list on pages 18-19. A category of health care provider approved to deliver services under UMP Neighborhood. *Approved* providers include network, out-of-network, and non-network providers. Some approved provider types, such as massage therapists, must be network providers for the purpose of UMP Neighborhood coverage. Approved provider type does not infer that self-referral is permitted (see "Other Health Care Services" for a list of providers to whom you may self-refer).

Brand Name Drug

A particular drug product sold under the proprietary name or trade name selected by the manufacturer.

Calendar Year

January 1 through December 31.

Care System

Small, customized health care provider networks chosen to participate in UMP Neighborhood. Participating care systems have demonstrated ability to provide cost-effective care and commitment to participate in clinical quality initiatives. UMP Neighborhood enrollees must enroll in a care system through which primary and specialty health care services are provided.

Chemical Dependency

An illness characterized by a physiological or psychological dependency on a controlled substance or on alcoholic beverages.

Coinsurance

The percent of allowed charges that UMP Neighborhood pays for covered services. See also the definition of enrollee coinsurance (used to refer to the percent you pay or "enrollee cost-share").

Copayment

A dollar amount you pay when receiving specific services, treatments, or supplies, such as an inpatient hospitalization in a care system facility, emergency room care, or a prescription filled through our mail-service pharmacy.

Custodial/Convalescent Care

Care primarily to assist in activities of daily living, including institutional care primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervising medications that are ordinarily self-administered. UMP Neighborhood reserves the right to determine which services are custodial/convalescent care.

Domestic Partner

A qualified same-sex domestic partner is one who meets the requirements described on the *Declaration of Marriage or Same-Sex Domestic Partnership* form available from the HCA or your agency's personnel, payroll, or insurance office.

Durable Medical Equipment

Equipment that is:

- Designed for prolonged use;
- For a specific therapeutic purpose in treating your illness or injury;
- Medically necessary;
- Prescribed by the attending approved provider; and
- Primarily and customarily used only for a medical purpose.

Emergency

See Medical Emergency.

Enrollee

An employee, retiree, former employee, or dependent enrolled in UMP Neighborhood.

Enrollee Coinsurance

The percentage you are required to pay on claims for which UMP Neighborhood pays less than 100% of allowed charges.

Experimental or Investigational

A service or supply is experimental or investigational if any of the following statements applies when the service is provided. The service or supply:

- Cannot be legally marketed in the United States without approval of the Food and Drug Administration (FDA), and that approval has not been granted.
- Is the subject of a current new drug or new device application on file with the FDA.
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate safety, toxicity, or efficacy.
- Is provided under a written protocol or other document that lists an evaluation of safety, toxicity, or efficacy among its objectives.
- Is under continued scientific testing and research concerning safety, toxicity, or efficacy.
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for safety, toxicity, or efficacy; or
- Is unsupported by prevailing opinion among medical experts (as expressed in peer-reviewed literature) as safe, effective, and appropriate for use outside the research setting.

In determining whether a service or supply is experimental or investigational, UMP Neighborhood relies exclusively on the following sources of information:

- The enrollee's medical records.
- Written protocol(s) or other document(s) under which the service is provided.
- Any consent document(s) the enrollee or enrollee's representative has executed, or will be asked to execute, to receive the service.
- Files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service is provided, and other information concerning the authority or actions of the IRB or similar body.
- Up-to-date, published peer-reviewed medical literature (as defined on page 75) regarding the service, as applied to the enrollee's illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by the U.S. Food and Drug Administration (FDA), Office of Technology Assessment, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.
- Information proving the provider has shown proficiency in the procedure, based on experience and satisfactory outcomes in an acceptable number of cases.
- Opinions from medical adviser specialists.

Explanation of Benefits (EOB)

A detailed account of each claim processed by a medical plan, which is sent to you to describe claim payment or denial.

Family

All eligible family members (subscriber and dependents) enrolled in a single account.

Fee Schedule

UMP Neighborhood's maximum payment amounts for specific services or supplies. Network providers have agreed to accept these fees as payment in full for services to UMP Neighborhood enrollees. See Allowed Charge definition for more details.

Formulary

See Preferred Drug List on page 75.

Generic Drug

Generic drugs have the same active ingredient as brand name drugs no longer under patent and are usually less expensive. Generic drugs use the official chemical title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary. Some are marketed under an alternate brand name.

Health Care Authority (HCA)

The Washington State agency that administers the following health care programs: Basic Health, Community Health Services, Prescription Drug Program, and Public Employees Benefits Board (PEBB). The HCA is also responsible for administering the Uniform Medical Plan PPO and UMP Neighborhood, as medical plan options for PEBB enrollees.

Home Health Agency

An agency or organization that provides a program of home health care prescribed by an approved provider type (practicing within the scope of its license as an appropriate provider of home health services) and is Medicare-certified, JCAHO-accredited, or a UMP Neighborhood network provider.

Hospice

A facility that provides short periods of direct or respite care for a terminally ill patient in a home-like setting. This facility may be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program, and it must be licensed by the state where services are performed or, if state licensure is not required, Medicare-certified or JCAHO-accredited.

Hospice Care Program

A formal Medicare-certified or JCAHO-accredited program directed by an approved provider to help care for a terminally ill patient. This may be through:

- A centrally administered, medically directed, and nurse-coordinated program that provides a system primarily of home care, uses a hospice team of professional and volunteer workers, and is available 24 hours a day, 7 days a week; or
- Confinement in a facility that operates as an integral part of the program to provide short periods of stay in a home-like setting for direct or respite care.

Hospital

An institution accredited as a hospital under the Hospital Accreditation Program of JCAHO and licensed by the state where it's located. Any exception to this must be approved by UMP Neighborhood.

The term hospital does *not* include a convalescent nursing home or institution (or part) that:

- Furnishes primarily domiciliary or custodial care;
- Is operated as a school; or
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

Maintenance Care

Medical services designed to preserve or retain a current level of activity or health. UMP Neighborhood reserves the right to determine which services constitute maintenance care.

Medical Emergency

The sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a reasonable, prudent layperson to believe:

- A health condition exists requiring immediate medical attention; and
- Failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organs, or would place the person's health in serious jeopardy.

UMP Neighborhood reserves the right to determine whether the symptoms indicate a medical emergency.

Medically Necessary Services, Supplies, or Interventions

UMP Neighborhood provides coverage for services, supplies, or interventions that are:

- Included as a covered service as described in the "Covered Expenses" section;
- Not excluded; and
- Medically necessary.

Except as provided under "Chemical Dependency Treatment" on page 24, a service is "medically necessary" if it is recommended by your treating provider and UMP's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply, or intervention is to treat a medical condition;
2. It is the appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply, or intervention is known to be effective in improving health outcomes; and
4. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. "Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention is not considered separately from the medical condition and patient indications for which it is being applied.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet

the standards of this definition of "medical necessity." UMP Neighborhood may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity"; however, UMP Neighborhood is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet UMP Neighborhood's definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for the patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

The fact a physician or other provider prescribes, orders, recommends, or approves a service or supply does not, in itself, make it medically necessary.

Preventive services not covered by the UMP Neighborhood preventive care benefit will still be covered under the medical/surgical benefit if medically necessary.

UMP Neighborhood may require proof that services and supplies, including court-ordered care, are medically necessary. No UMP Neighborhood benefits will be provided if that proof isn't received or isn't acceptable– or if UMP Neighborhood determines the service or supply is not medically necessary.

Network Provider(s)

Care system providers and certain other health care providers who have contracted directly with the UMP or are part of a provider network that has contracted with UMP to provide services to UMP Neighborhood enrollees at a reduced rate. When you use network providers, you cannot be billed for the difference between the provider's billed charge and UMP Neighborhood's allowed charge. Covered benefits are paid at the network level—the highest benefit level available through the plan. Network reimbursement level applies to services received from:

- Primary care providers, specialists, and ancillary providers listed in your care system's directory.
- Providers contracted with the UMP PPO network when your care system provider has notified UMP that you have been referred for medically necessary care not available within your care system.
- A provider of one of the types listed under "Other Health Care Services" on pages 15-16, who is a UMP PPO network provider.

Non-Network Provider(s)

Health care providers in Washington State who are not listed in your care system directory and to whom you self-refer (except for those UMP PPO network providers identified in "Other Health Care Services" on pages 15-16).

Many non-network providers can bill you for the difference between their billed charge and the allowed charge (see definition on page 70). This does not apply to providers contracted with the UMP PPO network.

Normal Benefit

The dollar amount of the benefit UMP Neighborhood would normally pay if no other health plan had the primary responsibility to pay the claim.

Open Enrollment Period

A period defined by the HCA when you have the opportunity to change to another health plan offered by PEBB for an effective date beginning January 1 of the next year.

Out-of-Network Provider(s)

Health care providers:

- Who do not have a contract with the UMP and to whom you have been referred by your care system provider for covered services not available within the care system, or
- To whom you have self-referred for urgent conditions or medical emergencies.

Most out-of-network providers can bill you for the difference between their billed charge and UMP Neighborhood's allowed charge (see definition on page 70).

Over-the-Counter Alternatives

An over-the-counter product equivalent to a prescription drug (identical active ingredients and strength) available in a comparable dosage form.

Over-the-Counter Drugs

Medications available for purchase without a prescription.

Partial Hospitalization

Ambulatory services provided in a hospital setting which permit the patient to return to his or her residence at night.

PEBB Plan

One of several health insurance plans, including the state's own self-funded preferred provider plans, UMP PPO and UMP Neighborhood, offered through the Public Employees Benefits Board (PEBB) program to public employees, former employees, retirees, and their dependents. Benefits and eligibility are designed by the PEBB and administered by the Health Care Authority (HCA) as part of a comprehensive employee/retiree benefits package.

Peer-Reviewed Medical Literature

Scientific studies printed in journals or other publications where original manuscripts are published only after being critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature, for example, does not include information from health-related Web sites or in-house publications of pharmaceutical manufacturers.

Plan-Designated Facility

A facility, such as a hospital, which is designated for the performance of a particular service(s) for an enrollee. Coverage for these services is dependent upon use of the designated facility. Such a designation will be made by UMP Neighborhood Medical Review, Case Management, or the UMP Medical Director.

Preauthorization

Approval by UMP Neighborhood for certain services before they are provided to the enrollee. Preauthorization is not a guarantee of coverage. Failure to preauthorize certain medical services or drugs could result in denial of the claim. Please see "Medical Review/ Preauthorization Requirements" starting on page 19 for medical/surgical services that require preauthorization, and "Drug Coverage Management" on pages 21-22 for drug classes that require preauthorization.

Preferred Drug List

A list of selected prescription medicines that assists the UMP in maintaining quality care while meeting cost-containment objectives for you and the UMP. The preferred drug list is reviewed regularly by an independent group of practicing health care providers to help ensure that the content is medically sound and supportive of your health. Enrollee coinsurance percentages and copayment amounts for brand name drugs vary depending on whether the drug is on the UMP Preferred Drug List (UMP PDL).

Prenatal

During the mother's pregnancy.

Primary Payer

The insurance plan required to process the claim first for all expenses allowed under its coverage when an enrollee is covered by more than one group insurance plan.

Professional Services

Non-facility medical/surgical services performed by professional providers such as medical doctors, doctors of osteopathy, naturopathic physicians, and advanced registered nurse practitioners.

Proof of Continuous Coverage

The Certificate of Creditable Coverage provided to the enrollee by the enrollee's prior health plan; or a letter from the enrollee's employer, on the employer's letterhead, providing the time period the enrollee and/or his or her dependent(s) were covered by health insurance.

Provider

An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Regionally Adjusted Charge

The maximum payment for a specific service or supply allowed under UMP Neighborhood fee schedules, when performed by out-of-network providers and non-network providers outside of Washington. UMP Neighborhood will establish regionally adjusted charges for each geographic area and service using one of the following:

- Medicare's allowable charge in the geographic region, inflated by a percent determined by UMP Neighborhood;
- Charges most frequently made by providers with similar professional qualifications for comparable services in the provider's geographic area (based on the 75th percentile of data collected by Ingenix, an organization that maintains the Prevailing Healthcare Charges System);
- Most consistent charge made by an individual provider for a particular service;
- The provider's actual charge after any discounts or reductions; or
- The UMP Neighborhood or Alternáre fee schedule.

UMP Neighborhood reserves the right to determine the amount payable for any service or supply.

Respite Care

Continuous care for a homebound hospice patient of more than four hours a day to provide family members temporary relief from caring for the patient.

Service Area

The Washington State counties of King, Pierce, and Snohomish. If Medicare is your primary coverage, see "UMP Neighborhood Provisions for Retirees on Medicare" starting on page 51 for exceptions. See page 7 regarding exception for student dependents attending school outside of this service area.

Skilled Nursing Facility

An institution, or part of an institution, that provides skilled nursing care 24 hours a day and is classified as a skilled nursing facility by Medicare. Skilled nursing facilities are not Medicaid-eligible, long-term care facilities.

Standard Reference Compendium

Refers to any of these sources:

- The American Hospital Formulary Service Drug Information.
- The American Medical Association Drug Evaluation.
- The United States Pharmacopoeia Drug Information.
- Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.

Subscriber

The individual or family member who is the primary certificate holder and UMP Neighborhood enrollee.

Substance Abuse Treatment Facility

An institution (or section) specifically engaged in rehabilitation for alcoholism or drug addiction that meets all of these criteria:

- Is licensed by the state;
- Keeps adequate patient records that contain course of treatment, progress, discharge summary, and follow-up programs;
- Provides services, for a fee, to persons receiving alcoholism or drug addiction treatment including room and board as well as 24-hour nursing; and
- Performs the services under full-time supervision of a physician or registered nurse.

Urgent Condition

A medical condition occurring suddenly and unexpectedly, or exacerbation of an existing condition that requires care and treatment as soon as possible to prevent the condition from becoming an emergency condition. In determining whether an urgent condition exists for the purpose of benefit payment, consideration will be given by UMP Neighborhood to the symptoms of the condition and the actions that would have been taken by a prudent person under such circumstances.